Supreme Court, U.S.
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No. _____

In the
Supreme Court of the United States

Sidney Esensten; Jeffrey A. Arenson; Family Medical Clinic, P.A., a Minnesota Non-Profit Corp.; Fairview, a Minnesota Non-Profit Corp.,

Petitioners,

v.

Dianne L. Shea,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

WHETHER ERISA PREEMPTS FRAUD CLAIMS ONLY AGAINST THE HEALTH MAINTENANCE ORGANIZATION PARTY TO AN ERISA CONTRACT, LEAVING THE PHYSICIAN PARTY EXPOSED TO THE POTENTIAL FOR UNLIMITED LIABILITY FOR ENTERING INTO THE SAME CONTRACT.

LIST OF PARTIES

Sidney Esensten, M.D.; Jeffrey Arenson, M.D.; and Family Medical Clinic, P.A., a Minnesota non-profit corp., the defendants at the district court, and respondents in the United States Court of Appeals for the Eighth Circuit, file this Petition for a Writ of Certiorari. Dianne L. Shea is the plaintiff and was the appellant at the Eighth Circuit. The caption lists all of the parties to this case as they appeared in the Eighth Circuit Court of Appeals. Fairview, however, is not a party to this Petition because the district court's dismissal of Fairview on statute of limitations grounds was affirmed by the Eighth Circuit. Further, Mrs. Shea voluntarily dismissed her lawsuit against United Healthcare, which included ERISA breach of fiduciary duty, as well as RICO claims. She also resolved her ERISA breach of fiduciary duty claims against Allina (a.k.a. Medica).

The Secretary of Labor intervened at both the district court and at the Eighth Circuit as amicus curiae on behalf of the plaintiff.

CORPORATE DISCLOSURE STATEMENT

At the relevant time, Drs. Esensten and Arenson were employees of the Family Medical Clinic, which is a nonprofit organization, with Fairview as its sole member.

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The Eighth Circuit's opinion and notice from the clerk of court regarding entry of judgment are reprinted in the appendix, at A-3 and A-1, respectively, and the opinion is published as Shea v. Esensten, 208 F.3d 712 (8th Cir. 2000). The district court's opinion from which plaintiff appealed to the Eighth Circuit is reprinted in the appendix, at A-17. An earlier opinion in this case which is relevant to these proceedings is reprinted in the appendix, at A-33, and is published as Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997), cert. denied, 522 U.S. 914 (U.S. Oct. 14, 1997).

JURISDICTION

The judgment and order sought to be reviewed was entered on March 31, 2000. The opinion for which the defendants file this Petition for a Writ of Certiorari for review by this Court was filed by a three-judge panel of the United States Court of Appeals for the Eighth Circuit on March 31, 2000. Judgment was entered on March 31, 2000. No petition for rehearing was sought. This petition is due ninety days after entry of judgment, or on June 29, 2000. Sup. Ct. R. 13.1. This petition was timely filed. This Court has jurisdiction to review the opinion of the Eighth Circuit pursuant to 28 U.S.C. § 1254(1) (1994).

APPLICABLE STATUTORY PROVISIONS

The primary statute at issue is ERISA preemption: 29 U.S.C. § 1144(a),(b) (1994); ERISA § 514(a),(b). Other relevant statutes include: 29 U.S.C. § 1002(1) (1994), ERISA § 3(1); and 42 U.S.C. § 300e(c)(2)(D) (1994). These provisions are all reprinted in the appendix at A-66.

STATEMENT OF THE CASE

Dr. Sidney Esensten, a family practice physician, treated Patrick Shea for many years for non-specific abdominal complaints, high cholesterol, ulcers, and conducted regular physical examinations of Mr. Shea. Mr. Shea had a family history of coronary artery disease; his brother and father were diagnosed with coronary artery disease and problems related to it. But Mr. Shea never had any symptoms of that disease while he received medical treatment from Drs. Esensten, Arenson and the Family Medical Clinic ("FMC"). Despite the lack of symptoms, Dr. Esensten ordered electrocardiograms (EKGs) and exercise stress tests because of the family history. Dr. Arenson, an internist and Dr. Esensten's partner, performed these tests. The tests were always negative, indicating it was unlikely that Mr. Shea had coronary artery disease. (See Expert op. of Drs. Tom Davis, Frazier Eales, and Nicholas Schneeman, 8th Cir. App., R.A. 35-57). The medical records establish that Mr. Shea never had symptoms of coronary artery disease, such as radiating chest pain. Id.

Mr. Shea did have abdominal complaints, and because of that, Dr. Arenson referred him to a gastroenterologist. Additionally, he had an episode of chest tightness when he was in Thailand on business in June 1992. Mr. Shea saw a cardiologist in Thailand, who performed a complete work-up, including blood tests, an EKG, and a stress test. All of these tests were negative, and the Thai cardiologist ruled out a cardiac cause for his symptoms. Mr. Shea continued to have non-specific abdominal complaints during the summer and early fall of 1992. He saw Dr. Arenson on October 6, 1992. He was not seen at the Family Medical Clinic again until February 1, 1993. At that time he had a complete physical examination and an EKG. The EKG was normal and the examination indicated no health problems. Mr. Shea experienced sudden cardiac death on March 5, 1993. The

autopsy report showed mild to moderate coronary atherosclerosis. Id.

Mr. Shea had his health insurance with Medica Primary. (See Medica Primary Certificate of Coverage, Exs. B & C to the Aff. of H. Zwak, 8th Cir. App. R.A. 70-168). He obtained this health insurance through his employer, Seagate Technology, which, in turn, contracted with Medica Primary. Medica Primary contracted with Drs. Esensten and Arenson's clinic, FMC and Fairview, to provide health care to Medica Primary insureds, such as Mr. Shea. (See Two Pool Primary Care Provider Agreement, Ex. C to the Aff. of C.M. Loidolt, 8th Cir. App., R.A. 169-200). Mr. Shea's health plan included referrals to specialists, contingent on a written referral from a primary care doctor.[1] Drs. Esensten and Arenson did not provide a written referral for Mr. Shea to see a cardiologist; and Mr. Shea never contacted Medica about the denial.

Mrs. Shea, as trustee for the heirs and next of kin of Mr. Shea, originally sued Drs. Esensten, Arenson, FMC, and Medica in Minnesota state court, Hennepin County, in June

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[1] Mr. Shea's medical plan in effect in 1992 stated the following with respect to referrals to specialists:

> **REFERRALS**: All Covered Health Services not provided by your Primary Care Office are Covered upon *written referral from your Primary Care Office* and some Covered Health Services are Covered only when provided in accordance with MEDICA PRIMARY's guidelines. See section 9 of this Certificate for requirements and procedures.

(See Medica Primary Certificate of Coverage, Exs. B & C to the Aff. of H. Zwak, 8th Cir. App., R.A. 70-168; quoted language appears on R.A. 71) (emphasis added). Section 9 of the certificate provides, in relevant part, "Members must obtain the required *written referral* prior to receiving services from a Participating provider other than the Member's Primary Care Office." (8th Cir. App. R.A. 98) (emphasis added).

1994. Her claims against the doctors and their clinic sounded in medical malpractice and fraud. (Original Compl.). Mrs. Shea brought the same fraud claim against Medica, and also sued it for tortious interference with contract. Id. The medical malpractice claim was for failure to refer Mr. Shea to a cardiologist and failure to diagnose coronary artery disease. This claim ultimately was tried to a state court jury in October 1999, which determined that the doctors were not negligent, and that Mr. Shea was negligent, but that his negligence was not the cause of his death. Thus, the state malpractice claim has been tried to a conclusion.

The fraud claim is the subject of this Petition. Mrs. Shea asserted that the contract (the Two Pool Primary Care Provider Agreement) between Medica and FMC contained financial incentives which influenced the doctors to refrain from providing medical benefits under his Medica plan, including specialty referrals. Mrs. Shea claimed that she and her husband requested a written referral to a cardiologist from Drs. Esensten and Arenson, but they refused to provide it. She claimed the doctors, the clinic and Medica should have abstained from entering into the contract which contained the financial incentives to limit medical benefits; or, alternatively, they should have disclosed all "relevant" aspects of the financial incentives to patients. (See Second Am. Compl., 8th Cir. Appellant's App., 108-133). All the defendants — Medica, the physicians and the clinic — were accused of the same wrongful conduct with respect to the managed-care contract. (See Original Compl., Counts Four, Five, and Six; Second Am. Compl., Count Three; Third Am. Compl., Count Two).

Medica removed the case to federal court on the grounds that the Employee Retirement Income Security Act of 1974 (ERISA) preempted the claims against it. Mrs. Shea brought a motion to remand, claiming ERISA did not preempt her claims against Medica. The district court disagreed, concluding that ERISA preempted the state law claims

because Mr. Shea's health plan would be a critical factor in establishing Medica's liability. (See Mem. and Order of Judge Diana E. Murphy, Oct. 12, 1994, App. A-59). Additionally, had Mr. Shea not enrolled in the plan, there would be no duty to him. Furthermore, Mr. Shea received his medical treatment from Drs. Esensten and Arenson because they were on a list of Medica providers. In other words, the doctor-patient relationship was a creature of the plan. Indeed, the district court noted that Medica's contract with the doctors was a necessary part of its provision of health insurance to Mr. Shea: "it would be impossible to administer a managed-care plan without agreements between the plan and participating doctors." Id at A-62.

Medica then brought a motion to dismiss all Mrs. Shea's state law claims against it on ERISA preemption grounds. The district court granted the motion. (See Order of Judge Paul A. Magnuson, Apr. 24, 1995, App. A-57).

The district court also allowed Mrs. Shea to amend the complaint to state ERISA breach of fiduciary duty claims against Medica, which she subsequently did. Id. Medica moved to dismiss for failure to state a claim. The district court granted that motion, holding there is no ERISA fiduciary duty to disclose to patients the plan's payment procedures or policies with physicians. (See Mem. and Order of Judge Magnuson, Nov. 15, 1995, App. A-40). The district court cautioned that allowing such a claim would lead to a requirement that ERISA health plans disclose to each plan participant the details of each care-provider's payment process, including amounts paid to each physician for each service the physician provides. It could also lead to claims against HMOs based solely upon a perceived disparity with the payment procedure. Id at A-54.

The district court then remanded the remaining claims against the doctors and clinic to state court in November 1995. While the claims were pending there, Mrs. Shea appealed the dismissal of her claims against Medica to the

Eighth Circuit. The Eighth Circuit affirmed the district court's ruling on ERISA preemption, but reversed the ruling as to an ERISA breach of fiduciary duty. Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997), cert. denied, 522 U.S. 914 (U.S. Oct. 14, 1997) (Shea I).

The Eighth Circuit observed that the ERISA preemption analysis was straight-forward:

> Here, Medica administered Seagate's employee benefit plan, and Mrs. Shea maintains Medica wrongfully failed to disclose a major limitation on her husband's health care benefits. Along these lines, we have held that claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision. . . . The outcome of Mrs. Shea's lawsuit would clearly affect how Seagate's ERISA-regulated benefit plan is administered, and if similar cases are brought in state courts across the country, ERISA plan administrators will inevitably be forced to tailor their plan disclosures to meet each state's unique requirements. **This result would be at odds with Congress's intent to ensure "the nationally uniform administration of employee benefit plans."**

Id., 107 F.3d at 627 (emphasis added).

The Eighth Circuit also held that Mrs. Shea stated an ERISA breach of fiduciary duty claim against Medica. Consequently, the payment policies between an HMO and the treating physician is material information about which a patient is entitled to know, if the incentives discourage the treating physician from providing essential health care. Id. at 629. However, the Court did not identify any such linkage between a financial incentive and reduced health care in this case, and the evidence shows there is none.

While the claims against the doctors and clinic were pending in state court in the spring of 1996, Mrs. Shea added Fairview as a defendant. The claims against Fairview were essentially the same as those against the doctors, the Clinic, and Medica for wrongfully entering into a managed-care contract, and for failing to disclose its terms. Fairview removed the case to federal court on ERISA preemption grounds. Mrs. Shea made a motion to remand, but the district court did not rule on the motion, as the ERISA breach of fiduciary duty claims against Medica had been revived by the Eighth Circuit.

In federal district court, Drs. Esensten, Arenson, and FMC made a motion for partial summary judgment on the fraud claim, again on ERISA preemption grounds. Fairview brought a motion for complete summary judgment on statute of limitations and ERISA preemption grounds. At the time that the district court heard and decided the motions, it was exercising its supplemental jurisdiction over the claims against the doctors, clinic, and Fairview, pursuant to 28 U.S.C. § 1367 (1994); but it was clearly deciding a federal question: ERISA preemption of state law claims.

The district court granted the motions, holding that ERISA preempted Mrs. Shea's state law fraud and misrepresentation claims, just as it preempted the same claim against Medica; and that Mrs. Shea's claims against Fairview were time-barred. (See Mem. and Order of Judge Magnuson, Mar. 5, 1998, App. A-17). In ruling that ERISA preempted the fraud claim against the doctors and FMC, the district court relied on the Eighth Circuit's ERISA preemption analysis as to Medica set forth in Shea I, and stated, "consequently, following the clear leading of the circuit court's opinion, the Court determines that Shea's fraud and negligent misrepresentation claims are preempted by ERISA and grants Defendants' motion to dismiss." Id. at A-25–26.

The district court observed that if Mrs. Shea's ERISA-based fraud claim survived, the policies of ERISA would be undermined:

> The allegations in Count Three [fraud and negligent misrepresentation] clearly reveal that the focus of Shea's attack is the plan itself, not Defendants' conduct per se. Specifically, Shea alleges that Defendants had a duty to disclose the financial arrangements in the plan that affected treatment or that Defendants should have abstained from entering into the ERISA plan altogether. If Shea's common law challenge to the existence of the plan were successful, it would undermine the congressional policies underlying ERISA.

Id. at A-25. The district court granted Fairview's motion to dismiss on statute of limitations grounds.

The medical malpractice claim ultimately was remanded to state court in November, 1998, and was tried to a state court jury in October 1999. The jury returned a verdict in favor of the defendants, finding that there was no negligence by the doctors and clinic. Mrs. Shea tried to present evidence of the plan's financial incentives in her malpractice case, but the trial court ruled that this evidence was not relevant to the malpractice claim. Mrs. Shea has appealed this ruling and the case is now pending before the Minnesota Court of Appeals. Thus, every aspect of the malpractice claim against the doctors has been litigated in state court. What remains is an ERISA-plan based fraud claim for the doctors' participation in a managed-care contract, and failure to disclose details of the contract to Mr. Shea.

In the meantime, Mrs. Shea appealed the federal district court's dismissal of the fraud claim to the Eighth Circuit. The Eighth Circuit had jurisdiction to hear the appeal pursuant to 28 U.S.C. § 1291 (1994). Oral argument was heard on

November 17, 1999, shortly after the malpractice trial in state court. The Eighth Circuit issued its decision on March 31, 2000 and judgment was entered that day. (See 8th Cir. op. filed Mar. 31, 2000, App. A-3; published as: Shea v. Esensten, 208 F.3d 712 (8th Cir. 2000)(Shea II)). The Eighth Circuit affirmed the district court's dismissal of Fairview, but reversed the district court's decision on ERISA preemption of the fraud claim against the doctors and FMC. Id. The Eighth Circuit remanded the fraud claim to the federal district court, with instructions that it be remanded to the state court for further proceedings. Id.

The Eighth Circuit held that ERISA did not preempt the fraud claim against the doctors, even though it had held in Shea I that the identical fraud claim against Medica was preempted. The distinguishing feature, according to the Eighth Circuit, was that Medica was an ERISA plan fiduciary, and therefore ERISA preemption applied to the claims against it. But the doctors and clinic were not plan fiduciaries and, therefore, the fraud claim against them was not preempted. Shea II, 208 F.3d at 719.

Whether ERISA preempts a fraud claim against a non-fiduciary defendant based on the existence of managed-care incentives in an employee welfare benefit plan, and the failure to disclose such incentives to a patient, is an important issue of federal law that has not been, but should be, decided by this Court. This Court has recently held that HMOs cannot be sued under ERISA for entering into a financial incentives managed-care contract. Pegram v. Herdrich, 503 U.S. ____, No. 98-1949, slip op. (U.S. June 12, 2000). The fraud claim in this case would hold doctors liable for exactly the same activity, but without the protection of the limited liability under ERISA. Yet the state malpractice claim against these doctors has already been tried to a jury, resulting in a defense verdict. The remaining fraud claim has nothing to do with the medical treatment rendered — or the medical decisions made — by these doctors. Instead, Mrs. Shea seeks to hold them

liable despite providing perfect medical treatment, based solely on their managed-care contract with Medica.

Mrs. Shea seeks to require doctors to be experts in interpreting ERISA health plans. She would require them to inform every patient of the details of the contract that the doctors have with the HMO, including details about financial incentives. Mrs. Shea's campaign against managed-care financing of employee health plans is contrary to the congressional intent of ERISA, as well as the federal HMO act, 42 U.S.C. 300e (1996), which allows HMOs to share financial risk with physicians. See 42 U.S.C. § 300e(c)(2)(D) (1994). If not reversed, the Eighth Circuit's decision in Shea II will limit HMO liability under ERISA, while exposing doctors to unlimited liability in state court for their participation in the very same contracts. Ironically, doctors typically do not even participate in drafting managed-care contracts, but because of the current law in the Eighth Circuit, they could have the most liability for entering into such contracts.

ARGUMENT

I. THIS COURT SHOULD ISSUE THE WRIT BECAUSE THE EIGHTH CIRCUIT DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW THAT SHOULD BE SETTLED BY THIS COURT.

A. INTRODUCTION

The important question of federal law that this Court should decide is whether ERISA preempts a fraud claim against doctors for entering into and failing to disclose a financial-incentive managed-care contract. Mrs. Shea's fraud claim would subject "the physician employee . . . to liability as a fiduciary on the same basic analysis that would charge the HMO." Pegram, slip op. at 24. ERISA preemption is

essential if a nationally uniform body of employee health benefits law is to be maintained.

Notably, petitioners are not arguing in favor of ERISA preemption of negligence or medical malpractice claims. Petitioners acknowledge Mrs. Shea had a cause of action for medical malpractice, based on the alleged failure to diagnose coronary artery disease and refer the decedent to a cardiologist. A Minnesota state jury heard that claim and found that there was no negligence. Mrs. Shea's fraud claim is not akin to a claim of traditional negligence or malpractice for medical care. She is attempting to create a new, separate cause of action that attacks the managed-care contract between the doctors and the HMO, where the contract exists as part of an ERISA plan. ERISA preempts precisely such claims.

It is fundamentally unjust to expose doctors to the potential for unlimited liability while affording HMOs limited liability under ERISA based on the same managed-care contract. But this surely will be the result without ERISA preemption of this fraud claim. Thus, this is not a simple state law issue, as Mrs. Shea contends. To label the fraud claim as a simple state-law "failure to disclose" claim is to understate the gravity of the onerous task Mrs. Shea seeks to impose upon doctors. In fact, Mrs. Shea would have the doctors abstain from the contract entirely. (See Second Am. Compl., ¶ 79). But failing that, she would require doctors to become health insurance experts for their patients, or else face liability whenever the doctor has not made a detailed disclosure of the contract.

Requiring doctors to disclose the intricacies of managed-care contracts to patients is far more burdensome than imposing that requirement on HMOs. Doctors do not draft the contracts. Drs. Esensten and Arenson had no part in drafting the contract at issue in this case. Yet, under the Eighth Circuit's decision, doctors will have the greatest exposure to liability based on such contracts. The same will

be true in future cases: doctors may be exposed to limitless liability in some jurisdictions, while HMOs will have nationally uniform and limited liability (if any) in federal court under ERISA. Doctors may now be required to learn the details of each managed-care contract that they service, and to determine what should be told to each patient about a particular contract, and when it should be told. This is an impossible task for physicians to accomplish, especially in light of all the other demands presented by practicing medicine.

The decision below is inconsistent with the national objectives of ERISA and undermines the policy concerns articulated in Pegram. The Eighth Circuit's decision threatens to undermine Pegram by substituting physicians for HMOs as the parties who can be sued for entering into financial-incentive health-care contracts. ERISA preemption of the fraud claim against the doctors is necessary to avoid this result. The Supreme Court should grant this petition and hold that ERISA preempts the fraud claim against these doctors.

B. THE PURPOSE AND GOALS OF ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to protect employees and their beneficiaries by imposing national standards on employee benefit plans. See 29 U.S.C. § 1001 (1994); ERISA § 2. Congress determined that the economic impact of employee benefit plans was becoming increasingly national. Further, the nation as a whole had an interest in protecting employee benefits. Id. This protection is accomplished by requiring disclosure of information, establishing standards for fiduciary conduct, and providing remedies, sanctions, and access to the federal courts. Id. ERISA governs both welfare plans and pension plans. 29 U.S.C. § 1002(1), (2) (1994); ERISA § 3.

Welfare plans include medical, surgical, and hospital care benefits. Id.

Congress intended to avoid a state-by-state "checker board" regulation of employee benefits law. Conflicting state laws would be contrary to the national interest. Congress thus intended ERISA to supersede any state laws or claims that "relate to" an employee benefit plan. 29 U.S.C. § 1144(a) (1994); ERISA § 514(a); See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987). ERISA preemption of state law claims also ensures that federal courts would have the sole power to adjudicate employee benefit plans. Congress drafted the preemption clause broadly to ensure federal regulation. Pilot Life, 481 U.S. at 46. As one of the Senate sponsors stated:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

Id. (emphasis added) (citations omitted). ERISA preemption protects against conflicting directives from one state to the next. In this case, ERISA preemption of the fraud claim would ensure that there would not be conflicting directives among the states concerning the propriety of physician participation in managed-care contracts. See Lancaster v. Kaiser Found. Health Plan, 958 F. Supp. 1137, 1150 (E.D. Va. 1997) (holding that fraud claim against physicians for failing to disclose cost-containment policy with the HMO was preempted by ERISA, thus preventing conflicting directives in various states).

Remedies under ERISA are limited. A participant may sue to recover benefits, enforce contract rights, or clarify rights to future benefits. 29 U.S.C.§ 1132(a) (1994); ERISA § 502(a). A plan participant may sue for other equitable — but not monetary — relief under section 502(a)(3) [29 U.S.C. § 1132(a)(3)]. See Mertens v. Hewitt Assoc., 508 U.S. 248 (1993). Thus, without ERISA preemption in this case, doctors are exposed to the potential for unlimited liability in state courts; while HMOs will have very little, if any liability for the same conduct. This is particularly true in light of this Court's holding in Pegram that HMOs cannot be held liable under ERISA for the existence of financial incentives in a managed-care contract.

C. THE PURPOSE AND GOALS OF MANAGED CARE

"Managed care" results from the need to contain mounting health care costs.[2] Traditionally, health care was financed on a fee-for-service basis, with health insurers assuming all the financial risk. The insurer was required to pay for any test, referral, or other service ordered by doctors. See Deven C. McGraw, Financial Incentives to Limit Services: Should Physicians be Required to Disclose These to Patients?, 83 Geo. L.J. 1821 (1995). This led to escalating health care costs. In response, Congress enacted a statute that led to the creation of health maintenance organizations (HMOs) and the sharing of financial risk between HMOs and physicians. See 42 U.S.C. § 300e. "The defining feature of

[2] The American Medical Association has defined managed-care as, "the control of access to and limitation on physician and patient utilization of services by public or private payers or their agents through the use of prior and concurrent review for approval of or referral to service or site of service, and financial incentives or penalties." See John K. Iglehart, Health Policy Report: The American Health Care System, 326 New Eng. J. Med. 962, 965 (1992).

an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed." Pegram, slip op. at 5. This Court further observed:

> The HMO thus assumes the financial risk of providing benefits promised: if a participant never gets sick, the HMO keeps the money regardless, and if a participant becomes expensively ill, the HMO is responsible for the treatment agreed upon even if its cost exceeds the participant's premiums. Like other risk-bearing organizations, HMOs take steps to control costs . . . These cost-controlling measures are commonly complemented by specific financial incentives to physicians, rewarding them for decreasing utilization of health-care services, and penalizing them for what may be found to be excessive treatment.

Id. at 5-6 (citation omitted). A cost-controlling method commonly used is "capitation," which involves payment by an HMO to physicians of a fixed dollar amount per enrollee, per month. See, McGraw, 83 Geo. L.J. at 1824. The capitation amount is calculated to cover all the primary care provider's costs. The capitated amount may also be calculated to cover any specialty care. Id. If the capitation amount does not cover these costs, the provider may be responsible for covering all or a portion of the deficit. Id. The contract between Medica and the physicians in this case was a capitation arrangement, including sharing of deficits and surpluses. (See Two Pool Primary Care Provider Agreement, 8th Cir. App., R.A. 169-200).

Congress expressly authorized this sharing of financial risk between HMOs and health care providers. 42 U.S.C. § 300e(c)(2)(D); Pegram, slip op. at 21. Accordingly, many health plans involve the sharing of financial risk between

HMOs and doctors. In most cases, these health plans are qualified ERISA welfare benefit plans. This is because managed-care organizations and HMOs primarily administer employee health plans. See Cynthia Ransburg-Brown, The Ultimate Jigsaw Puzzle: ERISA Preemption and Liability in the Utilization Review Process, 28 Cumb. L. Rev. 403 (1997-98). Furthermore, most people obtain their health insurance through their employer. See Iglehart, 326 New Eng. J. Med. at 965. Where such health insurance is offered as an employee benefit, it is considered an "employee welfare benefit plan" under ERISA. 29 U.S.C. § 1002(1)(A). Many employers now offer health benefits with an HMO under a managed-care arrangement, where there is financial risk-sharing between the HMO and the employee's health care provider. Here, the health plan at issue was an ERISA plan, and the medical benefits were provided under an HMO managed-care arrangement.

This Court recognized that the HMO structure of health care delivery must involve financial incentives in order for the HMO system to work:

> [N]o HMO organization could survive without some incentive connecting physician reward with treatment rationing. The essence of an HMO is that salaries and profits are limited by the HMO's fixed membership fees. This is not to suggest that the Carle provisions are as socially desirable as some other HMO organizational schemes; they may not be. But whatever the HMO, there must be rationing and inducement to ration.

Pegram, slip op. at 7-8 (citations omitted). The inducement to ration requires physician participation. But Mrs. Shea's fraud claim against all of the defendants has always been an attack on the Congressionally-authorized managed-care approach to the financing and delivery of health care. Hence, it is

inconsistent with this Court's holding in Pegram. What Pegram did not address, however, is whether doctors may be liable for participation in a managed-care incentives contract and the failure to disclose it. Accordingly, the Writ is necessary to correct the unjust result of HMOs having little or no liability for managed-care incentives under Pegram, while doctors would be exposed to the potential for unlimited state court liability for the same conduct under Shea II. This Court recognized in Pegram that physician participation is an integral part of the HMO financial incentive scheme. Petitioners now respectfully request this Court to grant the Petition and extend its Pegram analysis, thereby reaching the logical and just conclusion that doctors, like HMOs, cannot be held liable for participating in managed-care contracts, or for failing to disclose the details of those managed-care contracts, especially where the medical care provided was consistent with the standard of care.

D. THE EIGHTH CIRCUIT'S DECISION IS IN DIRECT CONFLICT WITH THE PURPOSE AND GOALS OF ERISA AND MANAGED CARE.

Mrs. Shea's fraud claim and the Eighth Circuit's holding are inconsistent with the policies underlying ERISA, and with authorized managed-care financing of health care. It also directly conflicts with this Court's Pegram decision. Unless reversed, it will undermine Congressional intent, as set forth in Pegram. This Court should grant the Petition to decide whether a fraud claim against doctors based on the existence of an ERISA-plan managed-care contract, and the failure to disclose it, is preempted by ERISA. If fraud claims such as this one become commonplace, physicians will be forced either to abstain from managed-care contracts or risk limitless liability for failing to disclose copious information regarding the intricacies of each patient's health care plan. Recognizing

that such a requirement would be wholly unworkable for HMOs, this Court wrote in Pegram:

> Nor would it be possible to translate fiduciary duty into a standard that would allow recovery from an HMO whenever a mixed decision influenced by the HMO's financial incentive resulted in a bad outcome for the patient. It would be so easy to allege, and to find, an economic influence when sparing care did not lead to a well patient, that any such standard in practice would allow a factfinder to convert an HMO into a guarantor of recovery.

Pegram, slip op. at 22.

Imposing this same fiduciary duty on physicians, who typically neither draft nor promote such plans, would be far more unworkable and clearly more unfair. This case perfectly illustrates this point. A state court jury has determined that these doctors provided care consistent with the professional standard, and adjudged them not negligent. Yet, this fraud claim is still being litigated, and, if successful, would make these doctors into guarantors of recovery. The irony of this egregious result is hard to miss, since, as the Eighth Circuit admitted, neither doctor is a fiduciary under the plan at issue.

The problem is not solved by calling this a simple issue of disclosure. The disclosure requirement Mrs. Shea would impose would lead to equally oppressive consequences. The Eighth Circuit's decision invites state law requirements that physicians learn the innumerable details of each health plan they service, as well as the details of their clinic's financial agreements with each provider, and disclose some or all of that information to patients. But under which circumstances this information must be provided is very unclear. Whether a duty to disclose arises only when a particular test or referral is indicated, or whether it arises whenever certain care is requested, or whether it arises every time a patient walks into

an examination room, will vary from state to state. And even those doctors who do make a disclosure still will be sued for not disclosing enough information, for disclosing the wrong information, or for disclosing information unclearly. HMOs, on the other hand, can very easily meet any disclosure requirement merely by conveying the existence of financial incentives in the employee health plan member handbook or certificate of coverage. Further, each HMO would be responsible for providing information only as to its own agreements; while doctors would be responsible for providing information as to each plan they service. But again, doctors typically have no part in drafting the HMO contracts.

Thus, the issue of disclosure might be a simple one for HMOs, which in the Eighth Circuit are subject to very limited, if any, disclosure liability under ERISA. But the issue of disclosure is insurmountably difficult for doctors. As a result of Shea II, doctors may now be subject to limitless liability for failing to disclose the intricacies of plans that change from year to year — sometimes week by week. Furthermore, disclosure requirements will be anything but uniform. For example, physicians in Virginia are not liable for the same failure to disclose that is alleged in this case. See Lancaster, 958 F. Supp. at 1150, (holding that fraud claim against doctors for failure to disclose financial incentives with HMO was preempted by ERISA).

Such a patchwork quilt of conflicting disclosure requirements is irreconcilable with Congress' goal of a nationally uniform application of employee benefits law. Unless Shea II is reversed, this Court's Pegram decision may not prevent the judiciary from "precipitat[ing] the upheaval" caused by the elimination of HMO practices that Congress has promoted for over 27 years. Pegram, slip op. at 20-21. In fact, the destruction of managed-care will occur more certainly, and more rapidly, if limitless fiduciary-type liability is imposed on physicians than if ERISA-limited fiduciary liability is imposed on the HMOs themselves. A raft of

decisions such as Shea II will make it impossible for physicians to enter into managed-care contracts. This is the very real crisis that may result throughout the country.

Congress intended that ERISA preemption would prevent exactly such conflicting results:

> Section 514(a) [ERISA's preemption clause] was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries. . . Particularly disruptive is the potential for conflict in substantive law. It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990). The Eighth Circuit's decision invites exactly such an outcome.

As this Court recognized in Pegram, Congress has already decided to allow managed-care financial incentives. 42 U.S.C. § 300e; Pegram, slip op. at 21. If there is to be a change, it should come from Congress, not the courts. See Ingersoll-Rand, 498 U.S. at 142. As it stands, the Eighth Circuit's opinion invites state courts to engage in "untethered assessments of permissible incentive levels in health care plans." See Herdrich v. Pegram, 154 F.3d 362, 383 (7th Cir.

1998), cert. granted, 120 S. Ct. 10 (1999) (Flaum, dissenting). As this Court held, "the Judiciary has no warrant to precipitate [such an] upheaval." Pegram, slip op. at 21. This Court articulated the danger of allowing claims that attack managed-care in these terms:

> Since inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others, . . . any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risk. A valid conclusion of this sort would, however, necessarily turn on facts to which courts would probably not have ready access: correlations between malpractice rates and various HMO models, similar correlations involving fee-for-service models, and so on. . . We think then, that courts are not in a position to derive a sound legal principle to differentiate an HMO like Carle from other HMOs.

Id. at 8-9. If the courts are not equipped to determine appropriate HMO incentive levels when the HMO is being sued, then they are not equipped to do so when the physician is being sued. The Supreme Court should grant the Petition and decide this important federal issue.

II. THE EIGHTH CIRCUIT'S DECISION CONFLICTS WITH DECISIONS OF THIS COURT.

This Court has decided a number of ERISA preemption cases, but not in the context presented in Shea II. The issue Shea II presents is an important question of federal law that should be settled by this Court. See Sup. Ct. R. 10(c).

In DeBuono v. NYSA-ILA Med. and Clinical Serv. Fund, 520 U.S. 806 (1997), this Court reviewed the kinds of claims that Congress intended ERISA to preempt. Notably, there is no requirement that the defendant be an ERISA fiduciary. Rather, the focus is on the nature of the claim and whether: (1) it forbids a method of calculating benefits; (2) it requires employers to provide certain benefits; (3) the existence of the plan is a critical element in establishing liability; or (4) the law or claim expressly refers to the ERISA plan. Id. at 814-15. This fraud claim is one that Congress intended ERISA to supersede, as set forth in DeBuono. The existence of Mr. Shea's plan is a critical factor in establishing liability. The District Court recognized this. But the Eighth Circuit has ignored DeBuono, and has thereby also ignored Congress' intent.

The Eighth Circuit's error is apparent when Shea II is compared to a recently decided Virginia case, Lancaster, 958 F. Supp. 1137. In Lancaster, the court reached the opposite conclusion as to the same legal theory at issue here. In Lancaster, the plaintiff sued her HMO, her medical clinic, and her treating physicians after the physicians failed to timely diagnose and properly treat a brain tumor. At the time of treatment, the HMO and the medical clinic had in place a financial incentive program "whereby physicians receive bonuses for avoiding excessive treatments and tests." Id. at 1140. In her complaint, the plaintiff alleged, inter alia, that each defendant committed actual and constructive fraud by establishing policies and guidelines that would financially benefit the physicians for not providing the promised care of reasonably prudent practitioners. Id. at 1141. The court first determined that the fraud claims as to the HMO were completely preempted, and therefore properly removed, since they challenged 'an administrative decision that [had] the effect of denying benefits.' The court then concluded that the fraud claim as to the physician-defendants also was

preempted pursuant to 29 U.S.C. § 1144(a). Lancaster, 958 F. Supp. at 1150. In so holding, the court stated:

> Permitting these claims to proceed would undermine the congressional policies that underlie ERISA. Absent preemption, for instance, benefit plans would be subject to conflicting directives from one state to the next concerning the propriety of such financial incentive policies. Further, the terms and conditions of the plan are a critical factor in establishing defendants' liability under these claims. Without the plan, there is no cause of action.

Id. The district court in Shea agreed: "[t]his Court agrees with the reasoning and conclusion as set forth by the Lancaster court." (See Mem. and Order of Judge Magnuson, Mar. 5, 1998, at A-27). Accordingly, because Mrs. Shea would have no fraud claim against the doctors in the absence of Mr. Shea's ERISA plan, and because the ERISA plan is a critical factor in establishing liability against the doctors under the fraud claim, the criteria for ERISA preemption under DeBuono is satisfied.

As the district court recognized, the essence of this fraud claim is grounded in the ERISA plan:

> While the doctor-patient relationship generally is accorded a great deal of deference, the relationship in this case is a creature of the ERISA plan. Medica and its doctors enter into contracts to provide medical services to plan members. In fact, it would be impossible to administer a managed-care plan without agreements between the plan and its participating doctors regarding procedures and payment.

(See Mem. and Order of Judge Murphy, at A-62).

Thus, if successful, Mrs. Shea's fraud claim would make it impossible to adopt the widely-used managed-care plan at issue here. Nor does this fraud claim involve an issue of traditional state-law regulation. By labeling the fraud claim as such, the Eighth Circuit misses the intent of ERISA uniformity. In fact, the Eighth Circuit identified the same claim against Medica as an issue of federal concern, and exclusively an ERISA claim. ERISA applies whether the defendant is an ERISA fiduciary or not.[3] Indeed, the Eighth Circuit ignored its own precedent when it held: "[w]e conclude that the analysis of Shea I does not apply to the present situation because here we are not dealing with the responsibilities of a plan fiduciary." See Shea II, 208 F.3d at 719. This holding is in direct conflict with the Eighth Circuit's previous pronouncement, consistent with Congressional intent, that: "whether [the defendant] is a

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[3] See Bast v. Prudential Ins. Co., 150 F.3d 1003, 1009-10 (9th Cir. 1998), cert. denied, 120 S.Ct. 170 (1999) (holding that plaintiff's state law claims against health insurer for refusal to precertify bone marrow transplant procedure were preempted by ERISA even though ERISA provided no remedy, stating, "We agree with our sister circuits that ERISA preempts state law claims, even if the result is that a claimant, relegated to asserting a claim only under ERISA is left without a remedy. The focus is on ERISA. If it does not provide a remedy, none exists."), citing Gibson v. Prudential Ins. Co., 915 F.2d 414, 417-18 (9th Cir. 1990) (because ERISA allows equitable relief against both fiduciaries and nonfiduciaries, Congress intended preemption to apply even where no ERISA fiduciary remedy exists); Cannon v. Group Health Serv., 77 F.3d 1270 (10th Cir. 1996), cert. denied, 519 U.S. 816 (U.S. Oct. 7, 1996) (ERISA preempts state law claims even if there is no alternative remedy under ERISA); See also, Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1333 (5th Cir. 1992), cert. denied, 506 U.S. 1033 (U.S. Dec. 14, 1992); Tolton v. American Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995); Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272, 1276 (6th Cir. 1991), cert. dismissed, 505 U.S. 1233 (1992) ("Nor is it relevant to an analysis of the scope of federal preemption that appellants may be left without a remedy.").

fiduciary or not does not affect our preemption analysis, and we hold [the plaintiff's] state law claims are preempted by ERISA." Consolidated Beef Indust., Inc. v. New York Life Ins. Co., 949 F.2d 960, 964 (8th Cir. 1991).

This Court recognized the federal nature of a similar claim against an HMO, when it granted the petition for a writ of certiorari in Pappas v. Asbel, 724 A.2d 889 (Pa. 1998), cert. granted, ____ U.S. ____, No. 98-1839 (U.S. June 19, 2000), with instructions that judgment be vacated, and the case remanded to the Pennsylvania Supreme Court, for further consideration in light of Pegram. In Pappas, the issue was whether ERISA preempted a negligence claim against an HMO, based on the HMO's refusal to authorize the transfer of the plaintiff to a university hospital for treatment of a neurological emergency. Id. The Pennsylvania Supreme Court held that the claim was not preempted by ERISA, because the claim did not "relate to" an ERISA plan. Id. The Pennsylvania Court recognized that the HMO's conduct in denying medical benefits was interwined with the provision of safe medical care. Id. at 893. But the court nonetheless held that claims involving the provision of medical care are not preempted. Id. The Pennsylvania Court's Pappas decision is in conflict with Pegram because HMO coverage determinations and medical determinations are "often practically inextricable from one another." Pegram, slip op. at 15-16. Thus, whether labeled as "negligence" or "fraud," if the claim attacks the HMO managed-care system of delivering medical treatment, as the claims did in Pappas and Pegram, it is preempted by ERISA, consistent with this Court's Pegram analysis. Taking the Pegram analysis to its logical conclusion, since physicians who contract with an HMO are inextricably part of the coverage and medical determinations, as in Shea, claims against them for conduct arising from their contracts with HMOs are also preempted. It does not matter whether the doctors are ERISA fiduciaries, as far as the ERISA preemption analysis is concerned.

Preemption of the fraud claim against the doctors is consistent with Congressional intent and this Court's preemption holdings. The focus must be on the nature of the claim; not on whether the defendant is an ERISA fiduciary. See DeBuono, 502 U.S. at 814-15. Accordingly, this Court should grant the Petition for a Writ of Certiorari and hold that ERISA preempts the fraud claim. This precise issue has not been, but should be, decided by this Court.

III. THE CONFLICT BETWEEN PEGRAM AND SHEA II INVITES INCREASED LIABILITY AGAINST PHYSICIANS FOR MANAGED-CARE CONTRACTS.

In Shea I, the Eighth Circuit upheld preemption for Medica. In Shea II, it denied preemption for physicians. It does not make sense that ERISA would preempt the fraud claim against Medica, but would not preempt the very same claim against the doctors. Mrs. Shea has never made a meaningful distinction between the two fraud claims, but contends that the plan itself imposes "a major limitation on [Mr. Shea's] health care benefits" which "Medica [and the doctors] wrongfully failed to disclose." Shea I, 107 F.3d at 627. If ERISA governs claims against an HMO for managed health care under an employee medical plan, it should govern the same claims against the doctors with whom the HMOs contract. This Court recognized in Pegram that a claim for breach of duty to disclose physician incentives to limit care might amount to breach of a fiduciary obligation under ERISA, if the information affects beneficiaries' material interests. Pegram, slip op. at 15, n. 8. Yet Shea II, if read beside Pegram, would encourage plan participants to pursue physicians for breaching a fiduciary obligation, thereby avoiding ERISA liability limitations. In other words, the combination of Shea II and Pegram could lead to physicians being held liable for breach of a "fiduciary duty," but they

would not have the benefit of limited liability under ERISA, while HMOs would. This Court recognized the danger of imposing liability on physicians as fiduciaries:

> The mischief of Herdrich's position, would, indeed, go further than mere replication of state malpractice actions with HMO defendants. For not only would an HMO be liable as a fiduciary in the first instance for its own breach of fiduciary duty committed through the acts of its physician employee, but the physician employee would also be subject to liability as a fiduciary on the same basic analysis that would charge the HMO.

Pegram, slip op. at 24. Mrs. Shea seeks to impose fiduciary liability on the doctors with unlimited state court liability, while HMOs have limited ERISA liability, if any. The Eighth Circuit's opinion invites placement of the lion's share of responsibility for managed-care contracts and of disclosing them to patients, on doctors' shoulders. But doctors should not be forced to shoulder this heavy burden when they are neither plan fiduciaries nor plan administrators, and have little or no part in designing managed-care contracts. The Supreme Court should grant the Petition for a Writ of Certiorari and hold that ERISA preempts the fraud claim.

CONCLUSION

This Court should grant the Petition to decide an important issue of federal law: whether ERISA preempts a fraud claim against doctors for entering into a managed-care contract used to finance an employee benefit plan, and for failure to disclose details of the contract to patients. The Writ is necessary to correct the unjust result of exposing doctors to limitless liability for entering into such contracts and not disclosing them, while HMOs would be exposed to very

limited liability under ERISA for the same conduct. The managed-care contract at issue in this case is one that has been authorized by Congress, and is used throughout the country. It is the same type of contract that was at issue in Pegram. What Pegram did not address, however, is whether doctors may be liable for participation in managed-care incentives contracts that are part of an ERISA plan, and for the failure to disclose them. Petitioners respectfully request this Court to grant the Petition, issue the Writ, and extend its Pegram analysis to the logical and just conclusion that doctors, like HMOs, cannot be held liable for participating in managed-care contracts, or for failing to disclose the details of those managed-care contracts, particularly when the doctors have provided medical treatment consistent with the professional standard of care. Consistent with Congressional intent, litigation against HMOs and doctors for the same alleged wrongful conduct arising out of an employee welfare benefit plan should be under ERISA to ensure nationally uniform application of the law.

Respectfully submitted,

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Dated: June 28, 2000.

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UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT
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March 31, 2000

Mr. Corey John Ayling
MCGRANN & SHEA
2200 LaSalle Plaza
800 LaSalle Avenue
Minneapolis, MN 55402-2041

Re: 99-1388 Dianne L. Shea vs. Sidney Esensten

Dear Counsel:

The court today issued an opinion in this case. Judgment in accordance with the opinion is also entered today.

Please review Federal Rules of Appellate Procedure and the Eighth Circuit Rules on post-submission procedure to ensure that any contemplated filing is timely and in compliance with the rules. Note particularly that petitions for rehearing and petitions for rehearing en banc must be received in the clerk's office within 14 days of the date of the entry of judgment. No grace period for mailing is allowed, and the date of the postmark is irrelevant. Any petition for rehearing or petition for rehearing en banc which is not received within the 14 day period for filing permitted by FRAP 40 may be denied as untimely.

(5148-010199)

Sincerely,

/s/
Michael E. Gans
Clerk of Court

paw

Enclosure(s)

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United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 99-1388

Dianne L. Shea,	*	
	*	
Appellant,	*	
	*	Appeal from the United
v.	*	States District Court for the
	*	District of Minnesota.
Sidney Esensten; Jeffrey A.	*	
Arenson; Family Medical	*	
Clinic, P.A., a Minnesota	*	
Non-Profit Corp., Family	*	
Medical Clinic; Fairview, A	*	
Minnesota Non-Profit	*	
Corp.; Medica, a Minnesota	*	
Non-Profit Corp.; United	*	
Healthcare, United	*	
Healthcare Corp., a Minnesota	*	
Non-Profit Corp.; Secretary	*	
of Labor; Allina Health	*	
System Corp.,	*	
	*	
Appellees.	*	
	*	
----------	*	
Secretary of Labor,	*	
	*	
Amicus on Behalf of	*	
Appellant.	*	

Submitted: November 18, 1999
Filed: March 31, 2000

Before BOWMAN, LAY, and HANSEN, Circuit Judges.

HANSEN, Circuit Judge.

Dianne L. Shea brought this wrongful death suit in state court after her husband's death due to heart failure, and the case now has been twice removed to federal court. In this latest removal proceeding, the district court dismissed the tort claim of count III (alleging negligent misrepresentation for the failure of Mr. Shea's physicians to disclose a conflict of interest) as preempted by ERISA.[1] The district court also dismissed a corporate party (Fairview) on statute of limitations grounds. Mrs. Shea appeals the preemption issue, joined by the Secretary of Labor as amicus curiae,[2] and the defendants move to dismiss the appeal as moot. We affirm in part, reverse in part, and deny the motion to dismiss the appeal.

I.

Patrick Shea died of a heart attack at the age of 40 after being assured by his family doctors that a referral to a

[1] The Employee Retirement Income Security Act of 1974 (codified as amended at 29 U.S.C. §§ 1001-1461 (1994 & Supp. III 1997) and in scattered sections of Title 26 U.S.C.).

[2] The Secretary of Labor is charged with interpreting and enforcing all provisions of Title I of ERISA. See 29 U.S.C. §§ 1132(a)(2), (5), and 1135.

cardiologist was unnecessary given his age and symptoms. Although Mr. Shea offered to pay for the referral himself when his symptoms did not seem to be improving, his physicians persuaded him to trust their judgment that neither his age nor his symptoms justified a visit to a cardiologist. Following her husband's death due to heart failure, Mrs. Shea initially brought a wrongful death action in state court against two physicians (Sidney Esensten and Jeffrey Arenson); the Family Medical Clinic, now known as Fairview Clinics (the Clinic); and Medica (her husband's health maintenance organization (HMO), with whom his employer contracted to provide employee health care). Dianne Shea alleged in her suit that certain financial incentives built into Medica's contract with Mr. Shea's physicians were designed to minimize referrals to specialists. She further alleged that if her husband had known of these incentives, he would not have trusted his physicians' medical advice so completely but would have sought out the life-saving opinion of a specialist at his own expense.

Medica initially removed the case to federal court, contending that Mrs. Shea's tort claims were preempted by ERISA, 29 U.S.C. § 1144. Mrs. Shea then amended her claim to state that Medica breached its fiduciary duties under ERISA by not disclosing to plan participants the financial incentives designed to reduce referrals that it included in its physician contracts. The district court dismissed Medica, concluding that Mrs. Shea's state tort claims against Medica as the plan administrator were preempted by ERISA and that the amended complaint asserting a breach of fiduciary duty failed to state a claim, see Fed. R. Civ. P. 12(b)(6). The district court remanded to state court the remaining state law claims.

Mrs. Shea appealed to this court. We reversed the district court's Rule 12(b)(6) dismissal of Medica, concluding that Mrs. Shea's amended complaint adequately stated a claim of breach of fiduciary duty against Medica. See Shea v.

Esensten, *107 F.3d 625 (8th Cir.)* (Shea I), cert. denied, 522 U.S. 914 (1997). Specifically, we held that a plan administrator has a fiduciary duty to disclose all material facts affecting a plan participant's health care interests, including financial incentives that might discourage a treating physician from providing essential referrals for covered conditions. See id. at 629. Medica ultimately settled the claim against it.

Meanwhile, the remanded state tort action proceeded against the doctors and the Clinic in state court. Mrs. Shea moved to amend her complaint to add as a defendant Fairview, a Minnesota non-profit corporation that owns and operates the Clinic. The second amended complaint included count I, alleging medical negligence; count II, alleging breach of contract; count III, alleging fraud and negligent misrepresentation based on the doctors' failure to disclose the conflict of interest created by their contractual incentives; count IV, alleging the joint and several liability of Fairview for damages awarded in counts I through III; and count V, seeking punitive damages against all defendants.

Before the state court ruled on the motion to amend, Fairview removed the second amended complaint to federal court. The doctors and the Clinic then moved the federal district court for a partial dismissal. The district court dismissed count II, the breach of contract claim, without resistance by Mrs. Shea, and it is not at issue in this appeal. The district court dismissed count III, the fraud and negligent misrepresentation claim, as preempted by ERISA after concluding that the claim relates to the ERISA plan because it involves an administrative denial of benefits, not a medical decision. Fairview moved for and received a complete dismissal on statute of limitations grounds. The district court then remanded to state court the remaining negligence claim against the doctors and the Clinic as stated in count I. A state court jury ruled in favor of the doctors and the Clinic on that medical negligence claim.

Mrs. Shea now appeals the district court's conclusions on ERISA preemption and the statute of limitations. The defendants move to dismiss the appeal as moot.

II.

A. Motion to Dismiss

We begin by addressing the pending motion to dismiss. After this appeal was filed, Mrs. Shea's medical negligence claim of count I was brought to trial in state court where a jury resolved the claim in favor of the defendants, specifically finding that the doctors did not provide Mr. Shea with negligent care or treatment. The doctors and the Clinic then moved to dismiss the present appeal as moot, asserting that after the jury verdict, Mrs. Shea would not be able to prove that her husband was denied appropriate care, which they assert is an essential element of Mrs. Shea's remaining claim of fraud and negligent misrepresentation. Mrs. Shea resists the motion, asserting the appeal is not moot because the state jury verdict has yet to be tested by post trial motions and state appellate procedures. She further contends that even if the jury verdict withstands post trial and appellate scrutiny, her negligent misrepresentation claim does not automatically fail in light of the jury's determination that the physicians provided adequate care because the negligent misrepresentation claim carries its own, independent injury.

"Under Article III of the Constitution, federal courts may adjudicate only actual, ongoing cases or controversies. It is of no consequence that the controversy was live at earlier stages in this case; it must be live when we decide the issues." Doe v. Lafleur, 179 F.3d 613, 615 (8th Cir. 1999) (internal quotations omitted). If this case is indeed moot, we must dismiss the appeal to avoid rendering a merely advisory opinion. See id. However, we agree with Mrs. Shea's assertion that the appeal is not moot. The state court judgment

is not yet final. Also, in spite of the jury's conclusion in favor of the doctors on the negligent treatment claim, we believe that a jury could nevertheless consistently conclude that the defendants are liable on the independent negligent misrepresentation claim of count III.

Count III asserts a claim of negligent misrepresentation based on the physicians' failure to disclose a financial incentive to minimize referrals to specialists, which she asserts amounts to a conflict of interest. In Minnesota, the tort of negligent misrepresentation occurs when a person making a representation "ha[s] not discovered or communicated certain information that the ordinary person in his or her position would have discovered or communicated." Safeco Inc. Co. of Am. v. Dain Bosworth Inc., 531 N.W.2d 867, 870 (Minn. Ct. App. 1995). State professional ethics standards for physicians mandate disclosure of conflicts of interest, and the Minnesota courts have noted that "a physician's advice about treatment options should be free from self-serving financial considerations." D.A.B. v. Brown, 570 N.W.2d 168, 172 (Minn. Ct. App. 1997). "It is well accepted that patients deserve medical opinions about treatment plans and referrals unsullied by conflicting motives." Id. at 170. Minnesota law indicates that the breach of a doctor's state-imposed ethical duty to disclose financial incentives is a medical malpractice claim, requiring a showing of actual harm to state a cause of action. See id. at 171.

In count III, Mrs. Shea asserts that Mr. Shea's physicians negligently or fraudulently failed to disclose a financial conflict of interest in violation of state professional ethics and that this failure to disclose adversely influenced his decision to seek the advice of a specialist. She asserts that regardless of the quality of the actual treatment rendered by Mr. Shea's physicians (already adjudicated in state court to have been adequate), their failure to disclose a financial incentive caused Mr. Shea the independent injury of having been prevented from making an informed choice of whether to seek what

might have been a life-saving referral at his own expense. Because Mrs. Shea's negligent misrepresentation claim of count III asserts a distinct and independent injury from the negligent treatment claim asserted and adjudicated in count I, the state jury verdict in favor of the physicians on count I does not necessarily preclude a finding in favor of Mrs. Shea on count III. Therefore, we deny the defendants' motion to dismiss this appeal as moot.

B. ERISA Preemption

Moving to the merits of the appeal, we first consider whether the district court correctly concluded that Mrs. Shea's claim in count III is preempted by ERISA. Because the issue of ERISA preemption is a question of law involving statutory interpretation, we review de novo the district court's decision to dismiss a claim on grounds of preemption. See Prudential Ins. Co. of Am. v. National Park Med. Ctr., Inc., 154 F.3d 812, 818 (8th Cir. 1998).

Congress included an express preemption clause in ERISA, which provides that ERISA supersedes all state laws insofar as they "relate to" an employee benefit plan under ERISA. 29 U.S.C. § 1144(a); see Wilson v. Zoellner, 114 F.3d 713, 716 (8th Cir. 1997). The Supreme Court has constructed a two-part inquiry for determining whether a state law is preempted under this "relates to" provision. Under this analysis, a state law "relates to" an ERISA plan within the meaning of § 1144(a) if it (1) expressly refers to an ERISA plan, or (2) has a connection with such a plan. See California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 324 (1997); Wilson, 114 F.3d at 716.

We first conclude that there is no express reference to an ERISA plan here. Minnesota's law of negligent misrepresentation is a tort law of general application. "[I]t makes no reference to and functions irrespective of the

existence of an ERISA plan." Wilson, 114 F.3d at 717 (discussing Missouri's state law of negligent misrepresentation). The defendants assert that an express reference to an ERISA plan is at issue here because Mrs. Shea's claim would not exist absent an express reference to the incentives created by the ERISA plan's contract with Mr. Shea's physicians. We believe, however, that the defendants place too much emphasis on this reference to the plan in the lawsuit. It is true that to prove her claim, Mrs. Shea must demonstrate that the physicians' contract, which happens to be an ERISA plan in this case, created certain financial incentives for Mr. Shea's physicians. This is the evidentiary foundation for demonstrating a conflict of interest that the physicians may have been required to disclose under state law. This reference to the ERISA contract terms is not an express state law reference that "relates to" an ERISA plan within the meaning of the preemption clause, because the contract creating the financial incentive must be referenced regardless of whether or not that contract stems from an ERISA plan. The express reference to the ERISA plan that will arise in this tort suit is necessary to demonstrate the origin of the physician's potential conflict of interest under state law, but the plan itself is peripheral to the ultimate issue of whether the physicians violated the state ethical duty to disclose a financial conflict of interest. See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 661 (1995) (noting that there is no preemption "if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability") (internal quotations omitted). Accordingly, we conclude that the state law negligent misrepresentation claim of count III is not subject to ERISA preemption on the basis of an express reference to ERISA.

"A law that does not refer to ERISA plans may yet be pre-empted if it has a 'connection with' ERISA plans."

California Div. of Labor Standards Enforcement, 519 U.S. at 325. To determine the existence of this forbidden connection, the Supreme Court directs us to "look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive as well as to the nature of the effect of the state law on ERISA plans." Id. (internal quotations and citation omitted). In addressing the effect of the state law on an ERISA plan, we consider a variety of factors, including:

> [1] whether the state law negates an ERISA plan provision, [2] whether the state law affects relations between primary ERISA entities, [3] whether the state law impacts the structure of ERISA plans, [4] whether the state law impacts the administration of ERISA plans, [5] whether the state law has an economic impact on ERISA plans, [6] whether preemption of the state law is consistent with other ERISA provisions, and [7] whether the state law is an exercise of traditional state power.

Wilson, 114 F.3d at 717 (quoting Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc., 947 F.2d 1341, 1344-45 (8th Cir. 1991)).

Considering the Arkansas Blue Cross & Blue Shield factors, we first note that allowing this state tort suit to proceed would not negate any ERISA plan provision and would not affect the relations between primary ERISA entities. Physicians are responsible to follow their state law ethical rules regardless of any contractual relation with or obligation to an ERISA entity. Merely requiring physicians to disclose financial conflicts of interest that might affect a patient's treatment options does not alter or affect any plan provision, it simply discloses its existence. Additionally, nothing new will be required of an ERISA entity by allowing this tort suit against physicians for their violation of ethical

duties imposed by state law. (The ERISA fiduciary is already obligated to make this type of disclosure according to Shea I.)

Similarly, allowing a state tort claim to proceed against a physician for failure to disclose a conflict of interest would not impact the structure, administration, or economics of any ERISA plan. Mrs. Shea's claim does not attack the validity of a term of the ERISA plan nor is she making a claim for benefits under the plan. Contrary to the defendants' assertions, she does not assert in count III that her husband was denied a referral or "benefit" to which he was entitled under the plan. Mr. Shea made no request for a referral of the plan administrator. Furthermore, his physicians were not plan administrators, and their medical advice cannot be classified as an administrative denial of plan benefits. Mr. Shea relied on his physicians' advice that a referral to a specialist was not medically necessary given his symptoms. Count III asserts that he would not have relied so completely on their medical advice had he known of their financial conflict of interest. The Minnesota courts have held that "a physician's advice about treatment options should be free from self-serving financial considerations, [and] any cause of action based on that conduct necessarily flows from the therapeutic relationship" or "the process of rendering medical treatment." D.A.B., 570 N.W.2d at 172. Mrs. Shea's claim stems from "the process of rendering medical treatment," id., and therefore, it would not affect the structure, administration or economics of the ERISA plan.

The district court concluded that the negligent misrepresentation claim of count III was preempted for the same reason that Mrs. Shea's claim against Medica, a plan fiduciary, was preempted in Shea I. We respectfully disagree with this analysis. Our opinion in Shea I mandates that ERISA fiduciaries must disclose financial incentives that discourage a treating physician from providing referrals. 107 F.3d at 628-29. The physicians being sued in this case, however, are not ERISA fiduciaries. Cf. Hull v. Fallon, 188

F.3d 939, 943(8th Cir. 1999) (holding state law malpractice claim against a physician was preempted where the physician, acting as the plan administrator, denied a thallium stress test as a plan benefit), cert. denied, 68 U.S.L.W. 3433, 2000 WL 220289 (U.S. Feb. 28, 2000) (No. 99-1083). We conclude that the analysis of Shea I does not apply to the present situation because here we are not dealing with the responsibilities of a plan fiduciary. While our opinion in Shea I altered the administration of an ERISA plan by creating a duty to disclose on the part of plan administrators, a lawsuit to enforce an independent state-created duty to disclose on the part of the physicians (in a situation where the ERISA fiduciary failed to make proper disclosure) will not impact the structure, administration, or economics of the ERISA plan in any meaningful way. None of the above-listed factors favors preemption.

Finally, "[a]s is always the case in our pre-emption jurisprudence, where federal law is said to bar state action in fields of traditional state regulation we have worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." California Div. of Labor Standards Enforcement, 519 U.S. at 325 (internal quotations and alterations omitted). "[T]he historic police powers of the State include the regulation of matters of health and safety." De Buono v. NYSA-ILA Med. and Clinical Servs. Fund, 520 U.S. 806, 814 (1997). State regulation of the ethical responsibilities imposed upon physicians lies within this category. Nothing in ERISA attempts to preempt the entire field of health care or the regulation of professional standards for physicians. See Boyle v. Anderson, 68 F.3d 1093, 1110 (8th Cir. 1995) (stating, "'nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulations, which historically has been a matter of local concern'") (quoting Travelers Ins. Co., 514 U.S. at 661), cert. denied, 516 U.S.

1173 (1996). After considering the nature and effect of the state law suit involved here and finding that none of the Arkansas Blue Cross and Blue Shield factors listed above favor preemption in this case, we conclude that there is no impermissible connection between the negligent misrepresentation claim and the ERISA plan to justify preemption of count III.

C. Statute of Limitations

The district court granted summary judgment in favor of Fairview, concluding that Mrs. Shea's attempt to amend the complaint to join this defendant to the suit was untimely. Mrs. Shea argues that the addition of this defendant should relate back to the original date of filing, because the two-year statute of limitations had run by the time she sought to add this defendant.

An amendment to a pleading relates back to the date of the original pleading if the party has received notice of the action so it will not be prejudiced in maintaining defense on the merits, and if the party knew or should have known that but for mistake concerning the identity of the proper party, the action would have been brought against this party in the first instance. See Fed. R. Civ. P. 15(c)(3). The determination of whether an amended pleading should be allowed and whether it relates back to the date of the original pleading are matters within the sound discretion of the trial court. See Zenith Radio Corp. v. Hazeltine Research, Inc., 401 U.S. 321, 330 (1971); see also Marchant v. City of Little Rock, Ark., 741 F.2d 201, 206 (8th Cir. 1984).

The district court found that Mrs. Shea did not bring the case against the wrong parties; she merely asserts she lacked knowledge of the financial and management relationship between the Clinic and Fairview. We agree with the district court that this asserted lack of knowledge does not satisfy the Rule 15 requirement that the plaintiff show an error

concerning the identity of the proper party or that Fairview should have known that the suit would have been brought against it but for a mistake in identifying the proper party. There was no mistake here. Mrs. Shea did not bring the suit against the wrong parties. She knew before the expiration of the statute of limitations that Fairview owned the Clinic. She knew the identity of Fairview but chose not to bring Fairview into the suit at that time. We find no abuse of discretion in the district court's conclusion that there is no relation back to the date of the original pleading in this situation.

D. Motion to Strike

Also pending is the defendants' motion to strike portions of the appellant's brief and appendix, specifically pages 376-504 of Mrs. Shea's appendix and any references to these documents in her brief. Fairview joined the motion but noted that pages 400-427 were before the district court at the time of its summary judgment ruling in March 1998. With this exception, we agree that the other documents at issue are not part of the record on appeal because they were not before the district court at the time it entered its summary judgment ruling. On appeal from a summary judgment ruling, the record before us includes evidentiary materials that were before the trial court when it made the summary judgment ruling, and we will not consider materials that became part of the district court file subsequent to that ruling. Barry v. Barry, 78 F.3d 375, 379 (8th Cir. 1996).

Mrs. Shea asserts that the information was not before the district court in a more timely manner because the doctors refused to produce the documents earlier. When she requested permission of the district court to file a motion to reconsider in light of this new evidence, however, the district court denied the request noting that the summary judgment decision in this case was based on ERISA preemption, which is a question of law, not on the basis of insufficient evidence.

Because the appeal involves a question of law, we conclude that Mrs. Shea has not offered a compelling reason why we should consider these records that were not submitted with the initial motion for summary judgment. We therefore grant the defendants' motion to strike material that was not before the district court at the time of its summary judgment ruling. We note that we did not consider the improper references to this material in our determination of this appeal.

III.

Accordingly, we deny the motion to dismiss the appeal as moot, we grant the motion to strike portions of the appellant's brief and appendix, and we reverse the district court's determination that count III is preempted by ERISA. Because the basis for removal no longer exists, we remand to the district court with instructions to remand count III to the state court. In all other respects, we affirm the judgment of the district court.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

Dianne L. Shea, individually and as trustee for the heirs of Patrick Joseph Shea, decedent,

Civil File No. 3-96-406

Plaintiff,

v.

MEMORANDUM AND ORDER

Sidney Esensten; Jeffrey A. Arenson; Family Medical Clinic, P.A., n/k/a Fairview Clinics, a Minnesota non-profit corporation; and Fairview, a Minnesota nonprofit corporation,

Defendants.

This matter is before the Court upon the Motion for Partial Dismissal brought by Defendants Dr. Sidney Esensten, Dr. Jeffrey A. Arenson, and Family Medical Clinic, P.A., and Defendant Fairview's Motion for Summary Judgment. In addition, the Court has before it appeals from Magistrate Judge Jonathan Lebedoff's order relating to discovery issues brought by these same Defendants. For the following reasons, the Court grants Defendants Esensten, Arenson, and Family Medical Clinic's Motion for Partial Dismissal and denies their Motion for Appeal of Magistrate's Order. The Court also grants Defendant Fairview's Motion for Summary Judgment and denies without prejudice as moot its appeal from the Magistrate Judge's order.

BACKGROUND

The following factual recitation is a summary of that contained in this Court's November 15, 1995, Memorandum and Order entered in this action. Plaintiff Dianne Shea's husband, Patrick Joseph Shea, died of heart failure at the age of forty. At the time of his death, Patrick Shea was under the care of Defendants Dr. Sidney Esensten and Dr. Jeffrey Arenson at Defendant Family Medical Clinic, P.A. ("Clinic"), which is overseen by Defendant Fairview.

Prior to his death, Patrick Shea had repeatedly expressed concerns to his doctors about his extensive family history of heart disease and his symptoms, which included chest pains, shortness of breath, muscle tingling, and dizziness, and had asked his doctors on numerous occasions whether he should see a cardiologist. The doctors allegedly assured him that he was not at risk, refused to refer him to a cardiologist, and discouraged him from seeking one out on his own. In the doctors' opinions, neither angioplasty nor bypass surgery was necessary. Patrick Shea died of a heart attack. The subsequent autopsy indicated severe blockage of the arteries which could have been eased by angioplasty.

Patrick Shea obtained his health insurance through his employer, Seagate Technologies, Inc. ("Seagate"). Seagate provided its employees with health care benefits by contracting with Defendant Medica, a health maintenance organization ("HMO"). Medica was to supply Patrick Shea with all of his medically necessary care. Medica, however, required him to obtain a written referral from his primary care physician before permitting him to see a specialist. Medica's contracts with its health care providers, such as Fairview, are structured to create financial incentives to the providers not to refer patients to specialists. Essentially, as Dianne Shea argues, Fairview loses money if its doctors make too many referrals and makes money if its doctors are stingy with referrals. Dianne Shea believes that this system of incentives

discouraged the defendant doctors from referring her husband to a cardiologist. She contends that if she and her husband had known about Fairview's arrangement with Medica, they would have been more skeptical of the doctors' refusals to refer Patrick Shea to a cardiologist and would have sought one out on their own.

Dianne Shea initially brought a wrongful death action in Hennepin County District Court, State of Minnesota. In addition to traditional medical malpractice claims and claims of breach of contract to provide ordinary skill and knowledge, Dianne Shea alleges that all Defendants fraudulently failed to disclose a financial conflict of interest caused by the doctor incentive programs. The original Complaint included Medica as a defendant. Medica removed the case to federal court, arguing that the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 ("ERISA" or "the Act"), preempts Shea's common law tort claims. The removed action was assigned the civil file number 3-94-1173. Then-Chief Judge Diana Murphy denied Plaintiff's motion for remand, holding that the fraudulent nondisclosure claim was "related to" ERISA and thus was preempted by ERISA. Shea amended her Complaint to allege that Medica violated its fiduciary duties under ERISA via its efforts to reduce covered referrals. Medica filed a motion to dismiss, which this Court granted on November 15, 1995, based on its finding that ERISA does not provide a remedy for failure to disclose this type of information. The Court then remanded the remaining claims to state court.

Dianne Shea appealed this Court's decision to the Eighth Circuit Court of Appeals. She also amended her Complaint, for the second time, in state court to include Fairview as a defendant. The Second Amended Complaint contains five counts. Count One (negligence) asserts a claim against Defendants Esensten, Arenson, and the Clinic for "negligently and carelessly failing to use reasonable care and skill in their care and treatment of" Patrick Shea. Count Two

(breach of contract) alleges that by failing to exercise ordinary skill and knowledge in treating Patrick Shea, Defendants Esensten, Arenson, and the Clinic "breached the standard of care that was an essential term of their contractual relationship." Count Three (fraud and negligent misrepresentation) contains claims against the same Defendants alleging that they "entered into contractual arrangements with Medica to treat participants in and beneficiaries of the Seagate Group Health Plan"; that these "contractual arrangements included significant bonuses and penalties designed to discourage referrals to specialists"; and that Defendants breached a duty to either "abstain from contracts such as those negotiated with Medica or to disclose to the patient their financial stake in the referral decision." Count Four (joint and several liability) alleges that Fairview, as either a coventurer or principal, is jointly and severally liable with the other Defendants for any award of compensatory damages under Counts One through Three. Finally, in Count Five, Shea seeks punitive damages based on allegations that all Defendants "acted with deliberate disregard for the rights and safety of" Patrick Shea by "deliberately creating a climate of hostility toward referrals, all to serve their selfish pecuniary interests." Fairview removed the action to this Court on May 1, 1996, and the case was assigned its present civil file number, 3-96-406. On May 31, 1996, Dianne Shea filed a motion to remand.

Prior to this Court's ruling on the motion to remand, the parties briefed and argued the appeal of this Court's dismissal of the Complaint in the 3-94-1173 file. The Eighth Circuit issued its opinion on February 26, 1997. In that opinion, the Eighth Circuit upheld the earlier decision that ERISA preempts Dianne Shea's common law tort claims against Medica. See Shea v. Esensten, 107 F.3d 625, 627 (8th Cir.), cert. denied, 118 S. Ct. 297 (1997). However, it reversed this Court's ruling of November 15, 1995, and held that Dianne Shea did state a claim against Medica for breaching its

fiduciary obligation to disclose all the material facts affecting her husband's health care interests. See id. at 628-29. The case was remanded to this Court for further proceedings. Recognizing the impact of the circuit court's decision on the then-pending motion to remand, the Court dismissed the motion without prejudice, but left open the possibility for Shea to refile such a motion at a later date if she deemed it necessary. The Court then ordered that the two cases (civil file numbers 3-94-1173 and 3-96-406) be consolidated under the civil file number 3-96-406.

Presently, Defendants Esensten, Arenson, and the Clinic have filed a motion for partial dismissal. Therein, they seek dismissal of Count Three of the Second Amended Complaint, which asserts a claim for fraud and misrepresentation.[1] (See Second Am. Compl. ¶¶ 73-82.) In addition, Defendant Fairview seeks dismissal of all counts and claims against it. These Defendants also appeal from Magistrate Judge Lebedoff's order regarding certain discovery issues. The Court now turns to resolving the issues raised in the motions and the appeal.

DISCUSSION

For the purposes of Defendants' Motion to Dismiss, the Court takes all facts alleged in Plaintiff's Complaint as true. See Westcott v. Omaha, 901 F.2d 1486, 1488 (8th Cir. 1990). Further, the Court must construe the allegations in the Complaint and reasonable inferences arising from the

[1] Defendants also move for summary judgment on Count Two, breach of contract. (See Second Am. Comp. ¶¶ 67-72). Plaintiff Shea does not oppose that aspect of Defendants' motions. Moreover, in her Third Amended Complaint, which was filed during the time that the present motions were taken under advisement, Plaintiff voluntarily withdrew her breach of contract claim. Accordingly, based on this concession, the Court grants Defendants' motions as to the breach of contract cause of action and dismisses Count Two.

Complaint favorably to Plaintiff. See Morton v. Becker, 793 F.2d 185, 187 (8th Cir. 1986). A motion to dismiss will be granted only if "it appears beyond doubt that the Plaintiff can prove no set of facts which would entitle him to relief." Id.; see Conley v. Gibson, 355 U.S. 41, 45-46 (1957). "The district court has discretion to determine how it will proceed on jurisdictional questions, however, and it may consider materials outside the pleadings such as depositions or affidavits in determining whether the record demonstrates lack of subject matter jurisdiction." Satz v. ITT Fin. Corp., 619 F.2d 738 (8th Cir. 1980) (citations and footnote omitted). The Court reviews the present motions with these standards in mind.

A. Defendant Doctors Esensten and Arenson and the Clinic

Defendants Esensten, Arenson, and the Clinic move for dismissal of Shea's claims for fraudulent nondisclosure and negligent misrepresentation in Count Three of the Second Amended Complaint. Defendants argue that these claims are preempted by ERISA, which provides the exclusive remedy for claims that relate to an employee health benefit policy. Shea contends that the alleged fraud and misrepresentation causes of action are merely medical malpractice claims that are not preempted. Thus, the question to be resolved in determining the propriety of preemption as to Count Three is whether it is "merely an ERISA claim for denial of benefits masquerading as a medical malpractice action, or, as [plaintiff sees] it, simply a state malpractice, negligence, and fraud action that defendants cannot dress up as ERISA claims." Lancaster v. Kaiser Found. Health Plan of Mid-Atl. States, Inc., 958 F. Supp. 1137, 1139 (E.D. Va. 1997).

ERISA is a comprehensive statute enacted to protect employees and their beneficiaries by regulating the creation and administration of employee benefit plans. See 29 U.S.C.

§ 1001(b). Pursuant to ERISA's preemption clause, 29 U.S.C. § 1144(a),[2] if a state law "'relates to" an employee benefit plan, it is preempted. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47-48 (1987). This preemption provision is expansive, "embracing common law causes of action if they have a connection with or a reference to an ERISA plan." Shea, 107 F.3d at 627. The breadth of this clause "indicates Congress's intent to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern.'" New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995) (quoting Alessi v. Raybestor-Manhattan, Inc., 451 U.S. 504, 523 (1981)). The text, however, cannot be read "to extend to the furthest stretch of its indeterminancy," which would make Congress's words of limitation a "mere sham." Id. at 655; see also De Buono v. NYSA-ILA Med. and Clinical Servs. Fund, 117 S. Ct. 1747, 1751 (1997). As pled in this case, Shea's claims for fraudulent nondisclosure and negligent misrepresentation are common law causes of action that "relate to" an employee benefit plan and are, therefore, preempted by ERISA.

In her appeal of this Court's decision in case number 3-94-1173, the Eighth Circuit was confronted with the same claims that are the focus of the present motion. There, the circuit court agreed with this Court's determination that Shea's fraudulent nondisclosure and misrepresentation tort claims against Medica were preempted by ERISA and, therefore, that the case was removable. See Shea, 107 F.3d at 627. In its decision, the court noted that removal jurisdiction is "intertwined with the district court's preemption ruling,"

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[2] Section 1144(a) provides that:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title....

and thus first considered whether ERISA preemption was proper under 29 U.S.C. § 1144(a). Id. The court stated that

> we conclude the district court correctly decided that ERISA preempts Mrs. Shea's state-law claims. The outcome of Mrs. Shea's lawsuit would clearly affect how Seagate's ERISA-regulated benefit plan is administered, and if similar cases are brought in state courts across the country, ERISA plan administrators will inevitably be forced to tailor their plan disclosures to meet each state's unique requirements. This result would be at odds with Congress's intent to ensure "the nationally uniform administration of employee benefit plans." Thus, we agree with the district court that Mrs. Shea's case was removable to federal court.

Id. (citation omitted). The circuit court, however, disagreed with this Court's decision that Medica had no duty to disclose its referral-discouraging approach to health care. The Eighth Circuit concluded that Patrick Shea had a right to know that Medica was offering financial incentives that "could have colored his doctor's medical judgment about the urgency for a cardiac referral." Id. at 629. Based on that conclusion, the circuit court reversed this Court's order dismissing Shea's Amended Complaint for failure to state a claim on which relief can be granted and remanded the case for further proceedings.

The Eighth Circuit's holding in Shea's first appeal–that the fraudulent nondisclosure and negligent misrepresentation claims are preempted by ERISA–applies to those same claims as asserted against Esensten, Arenson, and the Clinic. In Count Three, Shea alleges that Defendants' fraudulent nondisclosure and misrepresentation regarding its doctor incentive programs with Medica limited Patrick Shea's ability to make an informed choice about his health care. (See

Second Am. Compl. ¶ 81.) Specifically, Shea contends that Defendants "entered into contractual arrangements with Medica to treat participants in and beneficiaries of the Seagate Group Health Plan, which included decedent Pat Shea." (Id. ¶ 74.) Furthermore, the "contractual arrangements included significant bonuses and penalties designed to discourage referrals to specialists." (Id. ¶ 75.) Shea contends that Defendants had either a duty to refrain from entering into these contracts or a duty to disclose to a patient the financial stake inherent in the referral decision. (Id. ¶ 79.)

Properly construed, these claims attack an administrative decision, not a medical one. The allegations challenge the ERISA plan, with its financial incentives, that had the effect of denying benefits to Patrick Shea as a plan participant. In particular, the denial of benefits stemmed from the allegedly improper, non-medical influence that the incentive program had on Drs. Esensten and Arenson in treating Patrick Shea. As such, the claims are clearly "related to" the administration and regulation of the Seagate Plan. First, but for the existence of the plan, there would have been no incentive to deny Patrick Shea a referral to a cardiac specialist. In other words, without the ERISA plan, Shea has no basis for her claims. Second, absent preemption, benefit plans would be subject to conflicting requirements concerning the propriety of such financial incentive programs. The allegations in Count Three clearly reveal that the focus of Shea's attack is the plan itself, not Defendants' conduct per se. Specifically, Shea alleges that Defendants had a duty to disclose the financial arrangements in the plan that affected treatment or that Defendants should have abstained from entering into the ERISA plan altogether. If Shea's common law challenge to the existence of the plan were successful, it would undermine the congressional policies underlying ERISA. Consequently, following the clear leading of the circuit court's opinion, the Court determines that Shea's fraud and negligent

misrepresentation claims are preempted by ERISA and grants Defendants' motion to dismiss Count Three.

The Court's conclusion is corroborated by the holding in Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., 958 F. Supp. 1137 (E.D. Va. 1997). There, the district court reached the same conclusion based on similar facts. In Lancaster, the plaintiff sued her HMO, her medical clinic, and her treating physicians after the physicians failed to timely diagnose and properly treat a brain tumor. At the time of treatment, the HMO and the medical clinic had in place a financial incentive program "whereby physicians receive bonuses for avoiding excessive treatments and tests." Id. at 1140. In her complaint, the plaintiff alleged, inter alia, that each defendant committed actual and constructive fraud by establishing policies and guidelines that would financially benefit the physicians for not providing the promised care of reasonably prudent practitioners. See id. at 1141. The court first determined that the fraud claims as to the HMO were completely preempted, and therefore properly removed, since they challenged "an administrative decision that [had] the effect of denying benefits." Id. at 1147 (analyzing claim under 29 U.S.C. § 1132(a), ERISA's civil enforcement provision). The court then concluded that the fraud claim as to the physician-defendants was subject to the defense of ERISA preemption pursuant to 29 U.S.C. § 1144(a). See id. at 1150. In so holding, the court stated

> Permitting these claims to proceed would undermine the congressional policies that underlie ERISA. Absent preemption, for instance, benefit plans would be subject to conflicting directives from one state to the next concerning the propriety of such financial incentive policies. Further, the terms and conditions of the plan are a critical factor in establishing defendants' liability under these claims. Without the plan, there is no cause of action.

Id. Based on that conclusion, the court held that the fraud claims were preempted by ERISA and granted the motion to dismiss. This Court agrees with the reasoning and conclusion as set forth by the Lancaster court.

B. Defendant Fairview

Fairview moves to dismiss all claims against it arguing that they are time-barred by the applicable statute of limitations. Although Fairview brought the motion as one for summary judgment, failure to file within the statute of limitations is jurisdictional; thus, an untimely complaint deprives the district court of subject matter jurisdiction. See Diliberti v. United States, 817 F.2d 1259,1262-64 (7th Cir. 1987). Under Minnesota law, "all actions [against] hospitals ... for malpractice, error, mistake, or failure to cure, whether based on contract or tort. . ." shall be commenced within two years of the date on which the action accrued. Minn. Stat. § 541.07(1); see also Krause v. Farber, 379 N.W.2d 93, 97 (Minn. Ct. App. 1985) (holding misrepresentation claim against physician subject to section 541.07). The limitation period for a wrongful death action premised on medical malpractice begins when the underlying medical malpractice claim begins to run, not on the date of death. See DeRogatis v. Mayo Clinic, 390 N.W.2d 773, 776 (Minn. 1986). A medical malpractice claim accrues when the treatment for which the physician is retained terminates. See Goellner v. Butler, 836 F.2d 426, 430 (8th Cir. 1988).

In the case at bar, Shea asserts that Fairview, a hospital, is liable for the alleged malpractice and fraud perpetrated by Esensten, Arenson, and the Clinic. (See Second Am. Compl. ¶ 90) (alleging Fairview is jointly and severally liable for the conduct of Esensten, Arenson, and the Clinic). Patrick Shea last visited the Clinic in early October 1992. Thus, the limitations period for the claims expired in October 1994.

Shea, however, did not sue Fairview until May 1996, over one and one-half years after the expiration of the applicable two-year statute of limitations. Consequently, since the limitation period had expired before Shea sued Fairview, the claims against Fairview are untimely.[3]

In response, Shea argues that her claims against Fairview relate back to the timely filing of her original Complaint against the Clinic in June 1994. Specifically, Shea contends that the "identity of interest" between Fairview and the Clinic makes her tardy addition of Fairview permissible pursuant to the rules of civil procedure governing the amendment of pleadings. Moreover, Shea notes that her motion to amend the pleadings to add Fairview, which was filed in state court after the case was remanded, was granted by the state court on May 21, 1996. This Court finds these arguments unpersuasive. For the following reasons, the Court determines that Fairview was not properly added as a party to this litigation and dismisses the claims against it as untimely.

First, Shea's reliance on the state court order adding Fairview as a party is misplaced as it occurred after Fairview properly removed the case. Once a case is removed by a defendant, "the State court shall proceed no further unless and until the case is remanded." 28 U.S.C. § 1446(d). Only the federal district court can restore jurisdiction to the state courts. See Ward v. RTC, 972 F.2d 196, 198 (8th Cir. 1992). Thus, after removal has taken place, any order entered by the state court is void. See id.

In this case, Fairview received a courtesy copy of Plaintiff's Notice of Motion, Motion to Amend her Complaint to add Fairview as a defendant, and Proposed Amended Complaint on April 1, 1996. (See Fairview's Pet. For Removal at ¶ 1.) On May 1, within the thirty days required by

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[3] Even if the Court were to measure the limitation period from the date of Patrick Shea's death, March 3, 1993, the present action is time-barred.

statute, Fairview filed a notice of removal of the action. See 28 U.S.C. § 1446(b) ("notice of removal may be filed within thirty days after the receipt by the defendant . . . of a copy of an amended pleading, motion, order or other paper from which it may first be ascertained that the case is one which is or has become removable . . . ."). At the time removal was effected, the presiding state district court judge had Shea's motion to amend the pleadings under advisement. On May 21, the state district court judge signed and entered an order granting Shea's motion to amend the pleadings. However, since the action had been removed by that time, the state district court's May 21 order is void and is not binding on this Court.

Second, Shea has failed to establish that the addition of Fairview properly relates back to the original pleading. Whether an amendment adding a new party relates back depends on a showing that the amendment satisfies Federal Rule of Civil Procedure Rule 15(c).[4] Most importantly for this case, the rule allows an amendment adding a new party to relate back only if the new party "knew or should have known that, but for a mistake concerning the identity of the proper party, the action would have been brought against the party."

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[4] The Rule states in part:

An amendment of a pleading relates back to the date of the original pleading when . . .

(2) the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, or

(3) the amendment changes the party or the naming of the party against whom a claim is asserted if the foregoing provision (2) is satisfied and, within the period provided by Rule 4(m) for service of the summons and complaint, the party to be brought in by amendment (A) has received such notice of the institution of the action that the party will not be prejudiced in maintaining a defense on the merits, and (B) knew or should have known that, but for a mistake concerning the identity of the proper party, the action would have been brought against the party.

Fed. R. Civ. P. 15(c).

Fed. R. Civ. P. 15(c)(3) (emphasis added). In other words, the rule "'permits an amendment to relate back only where there has been an error made concerning the identity of the proper party and where that party is chargeable with knowledge of the mistake, but it does not permit relation back where. . . there is a lack of knowledge of the proper party.'" Worthington v. Wilson, 8 F.3d 1253, 1256 (7th Cir. 1993) (quoting Wood v. Worachek, 618 F.2d 1225, 1230 (7th Cir. 1980); see also Barrow v. Wethersfield Police Dept, 66 F.3d 466, 470 (2d Cir. 1995) ("Rule 15(c) does not allow an amended complaint adding new defendants to relate back if the newly-added defendants were not named originally because the plaintiff did not know their identities."), modified, 74 F.3d 1366 (2d Cir. 1996).

Here, Shea does not contend that she brought the case against the wrong parties. Instead, she claims that she "had no knowledge of the financial and management relationship between Family Medical Clinic and Fairview . . . ." (See Pl.'s Mem. Opp'n Fairview's Mot. Summ. J. at 13.) Shea ascribes this lack of knowledge to discovery delays and difficulties. This ignorance was purportedly cured when Plaintiff received discovery documents relating to the Clinic-Fairview relationship and when Plaintiff deposed the Clinic's Administrator, Jared Greupner, on April 23, 1996. At best, these bald assertions point to a lack of knowledge of a proper party, not the presence of "a mistake concerning the identity of the proper party." Fed. R Civ. P. 15(c). Consequently, under the circumstances, this Court concludes that there is no relation back of Shea's claims against Fairview, that all such claims against Fairview are dismissed as time-barred, and that Fairview should be dismissed as a party to this litigation.

C. Appeal From Magistrate Judge's Order

Defendants Esensten, Arenson, and the Clinic also filed a motion seeking reversal of Magistrate Judge Jonathan

Lebedoff's May 13, 1997, order, which compelled Defendants to produce all documents sought by Shea as set forth in her motion papers. The Court must modify or set aside any portion of the Magistrate Judge's order found to be clearly erroneous or contrary to law. See 28 U.S.C. § 636(b)(1)(A); Fed. R. Civ. P. 72(a); Local Rule 72.1(b)(2). Based on a review of the record and the submissions of parties, the Court concludes that the Magistrate Judge's order is neither clearly erroneous nor contrary to law. Accordingly, the Court denies Defendants' motion seeking reversal of the May 13 order.

In addition, Fairview filed an appeal from the May 13 order, which denied Fairview's motion to compel discovery and granted Shea's motion to compel discovery. In light of this Court's ruling dismissing Fairview as a party, Fairview's appeal is moot. Therefore, the Court denies it without prejudice.

CONCLUSION

Based on the Eighth Circuit's opinion, the Court determines that Shea's fraud and negligent misrepresentation claims against Defendants Esensten, Arenson, and the Clinic are preempted by ERISA. As pled, the claims challenge an administrative decision, not a medical decision. The Court therefore grants Defendants' motion and dismisses Count Three. In addition, the Court determines that Shea's claims against Defendant Fairview are time-barred by the applicable statute of limitations and that Shea has failed to show that these claims relate back to the filing of the original complaint. Consequently, the Court dismisses all counts and claims against Fairview and, accordingly, dismisses Fairview as a party to this litigation. Finally, having reviewed Magistrate Judge Lebedoff's May 13 order, the Court denies Defendants Esensten, Arenson, and the Clinic's motion for reversal as the order is neither clearly erroneous nor contrary to law. The

Court also denies without prejudice as moot Defendant Fairview's appeal of the same order since Fairview is no longer a party to this action.

Accordingly, **IT IS HEREBY ORDERED** THAT:

1. Defendants Dr. Sidney Esensten, Dr. Jeffrey A. Arenson, and Family Medical Clinic, P.A.'s Motion for Partial Dismissal (Clerk Doc. No. 72) is GRANTED;

2. Defendant Fairview's Motion for Summary Judgment (Clerk Doc. No. 75) is GRANTED;

3. Defendants Dr. Sidney Esensten, Dr. Jeffrey A. Arenson, and Family Medical Clinic, P.A.'s Motion for Appeal of Magistrate's Order (Clerk Doc. No. 63) is DENIED;

4. Defendant Fairview's Appeal (Clerk Doc. No. 65) from Magistrate Judge Jonathan Lebedoff's Order dated May 13,1997, is DENIED WITHOUT PREJUDICE AS MOOT;

5. All counts and claims against Defendant Fairview in the Second Amended Complaint (Clerk Doc. No. 1) are DISMISSED and Defendant Fairview is DISMISSED as a party to this litigation;

6. Count Two of the Second Amended Complaint (Clerk Doc. No. 1), which alleges breach of contract by Defendants Esensten, Arenson, and the Family Medical Clinic, P.A., is DISMISSED; and

7. Count Three of the Second Amended Complaint (Clerk Doc. No. 1), which alleges fraud and negligent misrepresentation as against Defendants Esensten, Arenson, and the Family Medical Clinic, PA., is DISMISSED.

Dated: March 5, 1998

/s/
Paul A. Magnuson
United States District Court Judge

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 95-4029MN

Dianne L. Shea, individually and as trustee for the heirs of Patrick Joseph Shea, decedent; individually and derivatively on behalf of participants in the Seagate Group Health Plan,	*	
Appellant,	*	
v.	*	Appeal from the United States District Court for the District of Minnesota.
Sidney Esensten; Jeffrey A. Arenson; Family Medical Clinic, now known as Fairview Clinics, a Minnesota non-profit corporation; Medica, a Minnesota non-profit corporation,	*	
Appellees.	*	

Submitted: November 21, 1996

Filed: February 26, 1997

Before FAGG, WOLLMAN, and HANSEN, Circuit Judges.

FAGG, Circuit Judge.

After being hospitalized for severe chest pains during an overseas business trip, Patrick Shea made several visits to his long-time family doctor. During these visits, Mr. Shea discussed his extensive family history of heart disease, and indicated he was suffering from chest pains, shortness of breath, muscle tingling, and dizziness. Despite all the warning signs, Mr. Shea's doctor said a referral to a cardiologist was unnecessary. When Mr. Shea's symptoms did not improve, he offered to pay for the cardiologist himself. At that point, Mr. Shea's doctor persuaded Mr. Shea, who was then forty years old, that he was too young and did not have enough symptoms to justify a visit to a cardiologist. A few months later, Mr. Shea died of heart failure.

Mr. Shea had been an employee of Seagate Technologies, Inc. (Seagate) for many years. Seagate provided health care benefits to its employees by contracting with a health maintenance organization (HMO) known as Medica. As part of its managed care product, Medica required Seagate's employees to select one of Medica's authorized primary care doctors. Mr. Shea chose his family doctor, who was on Medica's list of preferred doctors. Under the terms of Medica's policy, Mr. Shea was insured for all of his medically necessary care, including cardiac care. Before Mr. Shea could see a specialist, however, Medica required Mr. Shea to get a written referral from his primary care doctor. Unknown to Mr. Shea, Medica's contracts with its preferred doctors created financial incentives that were designed to minimize referrals. Specifically, the primary care doctors were rewarded for not making covered referrals to specialists, and were docked a portion of their fees if they made too many. According to Mr. Shea's widow Dianne, if her husband would have known his doctor could earn a bonus for treating less, he would have disregarded his doctor's advice,

sought a cardiologist's opinion at his own expense, and would still be alive today.

Initially, Mrs. Shea brought a wrongful death action in Minnesota state court. Mrs. Shea alleged Medica's fraudulent nondisclosure and misrepresentation about its doctor incentive programs limited Mr. Shea's ability to make an informed choice about his life-saving health care. Medica removed the case to federal court, contending Mrs. Shea's tort claims were preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144 (1994). Mrs. Shea filed a motion to remand, but the district court denied the motion. Mrs. Shea then amended her complaint to assert Medica's behind-the-scenes efforts to reduce covered referrals violated Medica's fiduciary duties under ERISA. See id. §§ 1002(21), 1104(a)(1). Believing ERISA does not require an HMO to disclose its doctor compensation arrangements because they are not "material facts affecting a beneficiary's interests," the district court dismissed Mrs. Shea's amended complaint for failing to state a claim. See Fed. R. Civ. P. 12(b)(6). Mrs. Shea appeals. Having construed the pleaded facts in the light most favorable to Mrs. Shea, we reverse the judgment of the district court. See Alexander v. Peffer, 993 F.2d 1348, 1349 (8th Cir. 1993).

Because our removal jurisdiction is intertwined with the district court's preemption ruling, we must first consider whether ERISA displaces Mrs. Shea's tort claims against Medica. See Schroeder v. Phillips Petroleum Co., 970 F.2d 419, 420 (8th Cir. 1992) (per curiam). ERISA supersedes state laws insofar as they "relate to any employee benefit plan." 29 U.S.C. § 1144(a). To this end, the language of ERISA's preemption clause sweeps broadly, embracing common law causes of action if they have a connection with or a reference to an ERISA plan. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47-48 (1987). Here, Medica administered Seagate's employee benefit plan, and Mrs. Shea maintains Medica wrongfully failed to disclose a major

limitation on her husband's health care benefits. Along these lines, we have held that claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision. See Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc., 999 F.2d 298, 301-04 (8th Cir. 1993); see also Howe v. Varity Corp., 36 F.3d 746, 752-53 (8th Cir. 1994) (ERISA preempts state fraudulent misrepresentation claims), aff'd, 116 S. Ct. 1065 (1996).

After considering the factors that guide our inquiry, see Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp. Inc., 947 F.2d 1341, 1344-45 (8th Cir. 1991), we conclude the district court correctly decided that ERISA preempts Mrs. Shea's state-law claims. The outcome of Mrs. Shea's lawsuit would clearly affect how Seagate's ERISA-regulated benefit plan is administered, and if similar cases are brought in state courts across the country, ERISA plan administrators will inevitably be forced to tailor their plan disclosures to meet each state's unique requirements. This result would be at odds with Congress's intent to ensure "the nationally uniform administration of employee benefit plans." New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1677-78 (1995). Thus, we agree with the district court that Mrs. Shea's case was removable to federal court. See Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64, 66-67 (1987) (ERISA preemption supports removal); Anderson v. Humana, Inc., 24 F.3d 889, 891 (7th Cir. 1994) (plan participant's attacks on HMO's incentive structure were both preempted and removable); Rodriguez v. Pacificare of Texas Inc., 980 F.2d 1014, 1016-17 (5th Cir. 1993) (state-law claims based on HMO's refusal to provide referral letter were properly preempted and removed,).

Having decided Mrs. Shea's case belongs in federal court, we turn to Medica's contention that Mrs. Shea lacks standing to pursue an ERISA remedy. ERISA authorizes current plan participants to assert a claim for breach of

fiduciary duty. See Adamson v. Armco, Inc., 44 F. 3d 650, 654 (8th Cir.), cert. denied, 116 S. Ct. 85 (1995). According to Medica, Mr. Shea was no longer a Seagate plan participant after he died. See 29 U.S.C. § 1002(7). Contrary to Medica's view, we have held that if the fiduciary's alleged ERISA violation caused the former employee to lose plan participant status, the former employee will nonetheless have standing to challenge the fiduciary violation. See Adamson, 44 F.3d at 654-55; see also Swinney v. General Motors Corp., 46 F.3d 512, 518-19 (6th Cir. 1995); Vartanian v. Monsanto Co., 14 F.3d 697, 702 (1st Cir. 1994). Mrs. Shea contends that, but for Medica's failure to disclose Mr. Shea's doctor's financial stake in discouraging covered referrals to specialists, her husband would still be alive and a current plan participant. Stated another way, Mr. Shea did not voluntarily relinquish his rights in the Seagate plan. See Adamson, 44 F.3d at 655. We are persuaded that Mrs. Shea, as the representative of Mr. Shea's estate, has standing to assert her husband's ERISA claims. Any other result would reward Medica for giving its preferred doctors an incentive to make more money by delivering cheaper care to the detriment of patients like Mr. Shea, and "ERISA should not be construed to permit the fiduciary to circumvent [its] ERISA-imposed fiduciary duty in this manner." Swinney, 46 F.3d at 518-19; see also Varity Corp. v. Howe, 116 S. Ct. 1065, 1068 (1996) (former plan participants tricked by a breach of a fiduciary duty have standing to sue).

With the jurisdictional challenges out of the way, we next consider whether Medica had a duty to disclose its referral-discouraging approach to health care. ERISA requires plan fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1). In addition to ERISA's express disclosure requirements, see 29 U.S.C. §§ 1021-1031, "'Congress invoked the common law of trusts to define the general scope of [a fiduciary's] . . . responsibility.'" Varity

Corp., 116 S. Ct. at 1070 (quoting H.R.Rep. No. 93-533, at 3-5, 11-13-(1973)). In affirming our decision in Varity Corp., the Supreme Court concluded that ERISA fiduciaries must comply with the common law duty of loyalty, which includes the obligation to deal fairly and honestly with all plan members. See id. at 1074-75. Although the Supreme Court found it unnecessary to reach the issue, our earlier opinion made clear that the duty of loyalty requires an ERISA fiduciary to communicate any material facts which could adversely affect a plan member's interests. See Varity Corp., 36 F.3d at 754. "The duty to disclose material information is the core of a fiduciary's responsibility, animating the common law of trusts long before the enactment of ERISA." Eddy v. Colonial Life Ins. Co. of Am., 919 F.2d 747, 750 (D.C. Cir. 1990).

Although the district court acknowledged Medica's duty of loyalty, the court felt the compensation arrangements between Medica and its doctors were not material facts requiring disclosure. We disagree. From the patient's point of view, a financial incentive scheme put in place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information. This kind of patient necessarily relies on the doctor's advice about treatment options, and the patient must know whether the advice is influenced by self-serving financial considerations created by the health insurance provider. The district court believed Seagate's employees already realized their doctors' pocketbooks would be adversely affected by making referrals to outside specialists. Even if the district court is right, Seagate's employees still would not have known their doctors were penalized for making too many referrals and could earn a bonus by skimping on specialized care. Thus, we conclude Mr. Shea had the right to know Medica was offering financial incentives that could have colored his doctor's medical judgment about the urgency for a cardiac referral. Health care decisions involve matters of life

and death, and an ERISA fiduciary has a duty to speak out if it "knows that silence might be harmful." Bixler v. Central Penn. Teamsters Health & Welfare Fund, 12 F.3d 1292, 1300 (3d Cir. 1993); see Restatement (Second) of Trusts § 173 cmt. d (1959). Indeed, in this case the danger to the plan participant's well being was created by the fiduciary itself. If Mr. Shea had been aware of his doctor's financial stakes, he could have made a fully informed decision about whether to trust his doctor's recommendation that a cardiologist's examination was unnecessary.

In sum, we believe Mrs. Shea has stated a claim against Medica for breaching the fiduciary obligation to disclose all the material facts affecting her husband's health care interests. When an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties. We thus reverse the district court's order dismissing Mrs. Shea's amended complaint for failure to state a claim on which relief can be granted and remand the case to the district court for further proceedings. We decline Medica's invitation to consider several remedy-related issues that were not addressed in the district court's ruling.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

Dianne L. Shea, individually and as trustee for the heirs of Patrick Joseph Shea; individually and derivatively on behalf of participants in the Seagate Group Health Plan,

Civ. File No. 3-94-1173

Plaintiff,

v.

MEMORANDUM AND ORDER

Sidney Esensten; Jeffrey A. Arenson; Family Medical Clinic, P.A., n/k/a Fairview Clinics, a Minnesota non-profit corporation; and Medica, a Minnesota non-profit corporation,

Defendants.

This matter is before the Court upon Defendant Medica's Motion to Dismiss the Plaintiff's claims brought under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* (ERISA), pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. There are also two appeals from Magistrate Judge Lebedoff pending before this Court.

BACKGROUND

Plaintiff Dianne L. Shea, a resident of Minnesota, is the widow and personal representative of Patrick Joseph Shea. Defendant Dr. Sidney Esensten is a physician specializing in family practice. Defendant Dr. Jeffrey A. Arenson is a physician specializing in internal medicine. Defendant Family Medical Clinic (Clinic) is a non-profit health care provider. Dr. Esensten and Dr. Arenson practice medicine at the Clinic. Mr. Shea was employed by Seagate Technologies, Inc. (Seagate), or the company that preexisted Seagate, beginning in 1979. Seagate created the Seagate Group Health Plan. Defendant Medica contracted with the Seagate Group Health Plan to administer and provide health coverage to Mr. Shea and his family, and contracted with the Clinic to provide health care to its subscribers pursuant to a health maintenance organization (HMO). Mr. Shea enrolled in the Medica Primary coverage offered by the Seagate Plan.

Mr. Shea died of heart failure at age 40, survived by Mrs. Shea and two minor children. Mr. Shea's father had died of heart disease while in his mid-fifties. His mother had died from conditions that included heart disease while in her fifties. Mr. Shea had two half-brothers, both of whom suffered from heart disease and underwent coronary bypass surgery while in their early forties.

The Clinic treated Mr. Shea during the 1980's for an ulcer. Dr. Esensten was aware that Mr. Shea's parents had died of heart disease or related conditions and that Mr. Shea's half-brothers underwent bypass surgery in their early forties. Dr. Esensten administered an echocardiogram in July 1989, and tested Mr. Shea's cholesterol level in August 1989. Mr. Shea altered his diet to limit high cholesterol foods and began exercising. However, over several years, his cholesterol level continued to rise. Mr. Shea informed Dr. Esensten that he began experiencing tingling and shortness of breath, and experienced dizzy spells. Dr. Esensten knew that Mr. Shea

was smoking one and one-half packs of cigarettes per day. Dr. Esensten stated to Mr. Shea that his symptoms did not warrant referral to a cardiologist, but he recommended a cardiopulmonary examination.

In January 1992, Dr. Esensten again advised Mr. Shea that his cholesterol level was too high. Dr. Esensten referred Mr. Shea to Dr. Arenson, under whose care Mr. Shea performed a treadmill test. A June 1992 cholesterol test revealed Mr. Shea's cholesterol level remained high.

Also in June 1992, while on a trip to Thailand, Mr. Shea was admitted to the hospital on complaints of dizziness, tightness in his chest and difficulty breathing. Thai staff administered nitroglycerin, which relieved Mr. Shea. The staff also administered a stress test during which an electrocardiogram monitored Mr. Shea's heart. The test showed normal cardiac function with no indication of ischemic heart disease. During Mr. Shea's Thai hospitalization, Dr. Esensten was in contact with the treating Thai physicians. Mr. Shea quit smoking on June 30.

Upon his return to the United States, Mr. Shea scheduled an appointment with Dr. Esensten at the Clinic. Mr. and Mrs. Shea visited the Clinic on July 6, 8, 11, and 22, and on August 10 and 14 of 1994. On each occasion except July 11, they met with Dr. Esensten. During these meetings Mr. Shea complained of shortness of breath, recurrent dizziness, tingling in his extremities, hyperventilation, chest pains at least weekly in the area of his heart and continuous lower back pain. The Sheas informed Dr. Esensten they would pay for the cardiologist's services if insurance did not cover them, and asked whether an angioplasty was in order. Dr. Esensten advised that an angioplasty was not in order and advised that a cardiologist was not necessary. Dr. Esensten referred Mr. Shea to Dr. Arenson.

Mr. Shea visited Dr. Arenson on August 19, 1992. Dr. Arenson noted Mr. Shea's hospitalization and treatment in Thailand. Mr. Shea informed Dr. Arenson of constant pain in

the lower quarter of his abdomen, and that he had experienced light-headedness and dizziness two weeks prior. Mr. Shea visited Dr. Arenson again on August 24, 1992. Mr. Shea informed Dr. Arenson that his abdominal pains continued. Dr. Arenson diagnosed the presence of a polyp and referred Mr. Shea for a colonoscopy at Fairview Riverside Hospital. The colonoscopy was performed on September 3, 1992, revealing a polyp 4 millimeters in diameter, 15 centimeters into the colon, and mild sigmoid diverticulosis.

Mr. Shea visited Dr. Arenson again on September 17, 1992. He informed Dr. Arenson of continued symptoms in his chest and hands. Dr. Arenson prescribed Xanax, a medication prescribed for digestive problems. At various times from August 30, 1989 through October 1992, Mr. Shea was prescribed the following medication: Zantac, Niosporin otic, Hismanal, Amoxillin, Mylanta, Mevacor, Flagyl, Lopid, Provachol, and Xanax.

Mr. Shea visited Dr. Arenson again October 6, 1992. Mr. Shea's cholesterol level remained high, but was marginally lower than it had been in June. Mr. Shea complained of sinus headaches and buzzing in his right ear. After that date, Mr. Shea experienced chest pains about once per week and continual lower back pain. He continued to experience regular tingling in his extremities and had spots on his feet. Mr. Shea had to sleep in an upright position.

Neither Dr. Esensten nor the Clinic referred Mr. Shea to a cardiologist. Mr. Shea was scheduled to perform another treadmill test on March 9, 1993.

On March 5, 1993, Mr. Shea experienced chest pains that extended down his arm. He left work early, intending to go to the Clinic. Mr. Shea did not arrive at the Clinic; he was found dead in his car at 9:00 p.m. that same day. An autopsy revealed 80% stenosis of the left anterior descending coronary artery and 50% to 56% stenosis of the right coronary artery. It also revealed moderate right ventricular hypertrophy and dilation, and moderate pulmonary edema. The coronary

arteries had mild to moderate arteriosclerotic changes at 4 centimeters from its origin.

Mrs. Shea brought this action in the State of Minnesota, Hennepin County District Court, in July 1994. The Defendants removed the action to this Court, and Mrs. Shea moved to remand to state court. Chief Judge Diana Murphy denied Mrs. Shea's motion to remand on October 17, 1994. In April 1995, this Court dismissed with prejudice Mrs. Shea's state tort claims against Defendant Medica, but gave leave for Mrs. Shea to amend her Complaint to include a breach of fiduciary duty claim under ERISA. Mrs. Shea filed an Amended Complaint alleging against Medica "Derivative Claims . . . under ERISA for Breach of Fiduciary Duty," "Direct ERISA Claims for Breach of Fiduciary Duty," and "Direct ERISA Claims for Arbitrary and Capricious Denial of Benefits." Medica now moves to dismiss all claims Mrs. Shea brings against it.

DISCUSSION

For the purposes of the Defendant's Motion to Dismiss, the Court takes all facts alleged in Plaintiff's Complaint as true. Westcott v. Omaha, 901 F.2d 1486, 1488 (8th Cir. 1990). Further, the Court must construe the allegations in the Complaint and reasonable inferences arising from the Complaint favorably to the Plaintiff. Morton v. Becker, 793 F.2d 185, 187 (8th Cir. 1986). A motion to dismiss will be granted only if "it appears beyond doubt that the Plaintiff can prove no set of facts which would entitle him to relief." Id.; see Conley v. Gibson, 355 U.S. 41, 45-46 (1957). Accordingly, the Court takes the preceding facts as alleged in Mrs. Shea's Amended Complaint to be true for the purposes of Medica's motion.

Medica bases its Motion to Dismiss on several alternative grounds: (1) that Mrs. Shea lacks standing to bring an ERISA breach of fiduciary duty claim; (2) that Mrs. Shea has alleged

no facts that indicate Medica breached its duties as a fiduciary; (3) that Mrs. Shea's claim for benefits violates this Court's Order granting her leave to amend her original Complaint; and (4) that the relief Mrs. Shea seeks is not available to her under ERISA. The Court need only address the first two bases, and does so in turn.

I. Standing to Bring ERISA Breach of Fiduciary Duty Claim

Medica argues Mrs. Shea lacks standing to bring a claim for breach of a fiduciary duty under ERISA. ERISA prohibits fiduciaries of ERISA-governed plans from breaching any of their "responsibilities, obligations, or duties." 29 U.S.C. § 1109(a). A fiduciary breaches its duty by misleading plan participants or misrepresenting the terms or administration of the plan. Anweiler v. American Electric Power Service Corp., 3 F.3d 986, 991 (7th Cir. 1993); Berlin v. Michigan Bell Telephone Co., 858 F.2d 1154, 1163 (6th Cir. 1988). Fiduciaries must also communicate material facts affecting a beneficiary's interests. Anweiler, 3 F.3d at 991; Rosen v. Hotel & Restaurant Employees & Bartenders Union, 637 F.2d 592, 599-600 (3d Cir.), *cent. denied,* 454 U.S. 898 (1981). The duty of a fiduciary to communicate material facts affecting a beneficiary's interests exists even if the beneficiary does not ask the fiduciary for the information. Anweiler, 3 F.3d at 991; Eddy v. Colonial Life Insurance Co., 919 F.2d 747, 750 (D.C. Cir. 1990).

ERISA allows a private action for breach of a fiduciary duty only if brought "by the Secretary, or by a participant, beneficiary or fiduciary." 29 U.S.C. § 1132(a)(2). Medica argues Mrs. Shea is none of these. Mrs. Shea asserts that Mr. Shea was a "participant" of the plan and would continue to be one but for Medica's breach, and that she brings her ERISA breach of fiduciary duty claim not in her own right but as a representative of his estate.

Medica argues essentially that when Mr. Shea died he ceased to be a "participant" within the meaning of § 1132(a). Indeed, Medica quotes the plan's Certificate of Coverage No. 391 Section XXV as explaining, "Unless otherwise specified in the Contract, your coverage ends . . . [t]he date the subscriber's coverage ends, including death of the subscriber." Additionally, as Mrs. Shea admits, "At the time of this action [Mr. Shea] was deceased and was no longer a plan participant.... After [Mr. Shea's] death, [Mrs. Shea] did not elect to continue benefits under COBRA." Am. Compl. ¶ 75.

Medica asserts that "[b]oth [Mrs. Shea] and Mr. Shea had been terminated as members of the Seagate Plan on March 31, 1993." Medica's Mem. Supp. Mo. Dismiss at 7. Medica relies on a string of cases to support this position. It is well supported that an ERISA plaintiff must strictly be a participant or beneficiary, or otherwise fit within the limited list of plaintiffs as stated by 29 U.S.C. § 1132(a). Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985); Gilquist v. Becklin, 675 F.Supp. 1168 (D.Minn. 1987), *aff'd,* 871 F.2d 1093 (8th Cir. 1988); Zinn v. Donaldson Co., 799 F.Supp. 69 (D.Minn. 1992); Joseph v. New Orleans Electrical Pension & Retirement Plan, 754 F.2d 628 5th Cir.), *cert. denied,* 474 U.S. 1006 (1985); Stanton v. Gulf Oil Corp., 792 F.2d 432 (4th Cir. 1986); Kuntz v. Reese, 785 F.2d 1410 (9th Cir.), *cent. denied,* 479 U.S. 916 (1986); Vilas v. Lyons, 702 F.Supp. 555 (D.Md. 1988). The cases clearly hold that a *former* plan participant simply is not a participant with standing to bring a breach of fiduciary claim under ERISA. Mrs. Shea's argument that "the word 'current' nowhere appears in the statute or in the legislative history [defining participant]," Pl.'s Mem. Opp. Mo. Dismiss at 8, ignores the language of ERISA and the cases applying ERISA.

However, the cases Medica relies on that reject standing involve former participants or other persons who voluntarily

terminated their rights under the plan. See Guilquist, 675 F.Supp. at 1170-71 (holding plaintiffs who voluntarily elected to withdraw from the plan and receive a lump-sum payment lacked standing); Zinn, 799 F.Supp. at 75 (holding the decedent's first wife who had entered an antenuptial agreement relinquishing marital property rights, and her children, all lacked standing under ERISA to claim breach of a fiduciary duty because they were not then nor could become beneficiaries under the decedent's profit sharing plan); Joseph, 754 F.2d at 630 (holding plaintiffs who reached retirement age and elected to receive a lump-sum retirement benefit in lieu of monthly benefits lacked standing to claim trustees of the plan breached their duties under ERISA); Stanton, 792 F.2d at 434-35 (holding plaintiff who retired and received benefits lacked standing to assert an ERISA breach of fiduciary duty claim where the fiduciary failed to inform the plaintiff of pending amendments to the plan that would have benefited the plaintiff had he postponed retirement); Kuntz, 785 F.2d at 1411 (holding that former employees who chose to receive vested benefits in a lump-sum were no longer plan participants and thus lacked standing to claim breach of fiduciary duty under ERISA); Vilas, 702 F.Supp. at 561-62 (holding a widow, who voluntarily waived her spousal rights to her husband's retirement benefits and whose husband had received a lump-sum payment of all his benefits before he died, lacked standing to bring a breach of fiduciary duty claim under ERISA).

Mrs. Shea claims that Mr. Shea, in whose stead she brings this action, would have remained a plan participant but for Medica's breach of its fiduciary duty. Particularly, Mrs. Shea asserts that Medica imposed "specific financial incentives and disincentives" regarding the making of referrals to specialists that caused Drs. Esensten and Arenson, as well as the Clinic, to refuse to refer Mr. Shea to a cardiologist, and that Medica had a duty to disclose the Clinic's "financial incentive to reduce referrals." Am. Compl.

¶¶ 75-79. Mrs. Shea asserts that had Medica disclosed the alleged financial disincentives to cardiologist referral, Drs. Esensten and Arenson would have referred Mr. Shea to a cardiologist and he would have received the necessary life-saving treatment the Clinic did not provide. In other words, Mrs. Shea argues Medica's breach ultimately caused Mr. Shea's death and the consequent *involuntary* termination of his plan participation.

Assuming, as the Court must, the truth of the facts as alleged by Mrs. Shea, and construing inferences from those facts in Mrs. Shea's favor, the issue here is more narrow than Medica suggests, and one of apparent first impression. That is, does a plaintiff lack standing due to the fact he is no longer a plan participant where he would be a plan participant but for the fiduciary's allegedly violative conduct? At least in dicta the Eighth Circuit has recently answered this question:

> Several circuits have crafted an exception to the [present plan participation] requirement for cases in which, "but for the employer's conduct alleged to be in violation of ERISA," the employee or former employee would be a plan participant. Other circuits have declined to adopt this exception. *We apparently adopted it without discussing the issue* in Howe v. Varity Corp., 36 F.3d 746 (8th Cir. 1994).

Adamson v. Armco, Inc., 44 F.3d 650, 654-55 (8th Cir.)(emphasis added and internal citations omitted), *cert. denied*, __ U.S. __ (1995). Medica attempted to distinguish Adamson at oral argument on this matter by asserting Adamson applies only to cases where the defendant takes affirmative steps to remove standing. However, the Adamson appellants had alleged a breach of fiduciary duty under ERISA on the basis that, *inter alia*, the fiduciary *failed* to inform participants the plans at issue were not funded. Id. at 654. The Court did not address the issue except in dicta as it

held the plaintiffs voluntarily relinquished participation through their own inaction by allowing their claims to become time-barred. Similar to the allegations of the appellants in Adamson, Mrs. Shea alleges the fiduciary failed to inform Mr. Shea, a plan participant at the time, of material information concerning the plan – that Medica imposed structural financial disincentives to a referral that would have kept Mr. Shea both alive and a plan participant. Unlike Adamson, the inferences from Mrs. Shea's Amended Complaint do not suggest Mr. Shea voluntarily relinquished participation in the plan.

The Adamson statement does not appear so restricted as Medica suggests, and Medica directs the Court to no contrary authority. Taking Medica's argument to its logical conclusion, Adamson would permit standing if a fiduciary actually lied to a participant and that lie induced the participant to end prematurely his plan participation; but would permit standing where a fiduciary instead intentionally misled a participant into ending prematurely his plan participation by simply withholding material information. As discussed above, however, under ERISA fiduciaries are required to communicate material facts affecting a beneficiary's interests even if the beneficiary does not ask the fiduciary for the information.

Applying Adamson to the facts as claimed here, the Court concludes Mrs. Shea has alleged that but for Medica's conduct in violation of ERISA Mr. Shea would have remained a plan participant. Standing will not be avoided by Medica's alleged violative conduct that purportedly proximately caused the involuntary end to Mr. Shea's plan participation. Because of this holding the Court does not reach Mrs. Shea's "derivative" status argument except to state that she has provided no support for the application of Rule 23.1 of the Federal Rules of Civil Procedure to this matter, or that Mr. Shea "is an equitable plan 'shareholder'" under that Rule.

II. Breach of Fiduciary Duty

Medica first argues that it is not a fiduciary. Medica cites no authority except Mrs. Shea's purported failure to state facts sufficient to demonstrate that Medica is a fiduciary. However, Mrs. Shea's Amended Complaint alleges Medica contracted with the Seagate Group Health Plan to administer and provide health coverage to Mr. Shea and his family, and contracted with the Clinic to provide health care to its subscribers pursuant to a health maintenance organization (HMO). Additionally, she alleges Medica administered the plan and structured financial incentives and disincentives to control the referral process for plan participants. A fiduciary is one who "exercises any discretionary authority or ... control respecting management of [the] plan or exercises any authority or control respecting management or disposition of its assets, ... or ... has any discretionary authority or discretionary responsibility in the administration of [the] plan." 29 U.S.C. § 1002(21)(A). Liberally construed, Mrs. Shea's Amended Complaint alleges facts sufficient to meet this definition.

Medica next asserts that the gist of Mrs. Shea's claim is physician malpractice, and that claims against HMOs based on physician malpractice do not implicate fiduciary duties under ERISA. In support, Medica relies on Kuhl v. Lincoln National Health Plan, 999 F.2d 298 (8th Cir. 1993), *cert. denied,* 114 S.Ct. 694 (1994). In Kuhl the Eighth Circuit affirmed the district court's refusal to permit a breach of a fiduciary duty claim under ERISA expressly because "monetary damages are not available under [29 U.S.C. § 1132(a)]," and the plaintiffs sought monetary damages instead of equitable relief. Id. at 304-5. Here, Mrs. Shea now seeks equitable relief for her claims against Medica. Thus, Kuhl does not support Medica's argument.

Similarly, Roen v. Massachusetts Mutual Life Insurance Co., No. 4-94-487 (D.Minn. Jan. 31, 1995), does not support Medica's position. In Roen, this Court held that the plaintiff's state claims of wrongful death and negligence were preempted by ERISA and did not fall within the ERISA saving clause exception. Additionally, the plaintiff in Roen stated that ERISA did not provide the relief the plaintiff sought. Id. at 8. The Court agreed that the factual allegations in the complaint failed to state a claim under ERISA. In that case a plan participant's son was evaluated by a psychologist who recommended in-patient chemical dependency treatment, but the corporation that had contracted with the insurance carrier to perform preadmission reviews approved only out-patient treatment. Within several days the participant's son committed suicide, and the trustee for his heirs and next of kin sued in his behalf for damages claiming the insurance carrier and the corporation performing preadmission reviews caused his death. Certainly those facts do not even suggest breach of a fiduciary duty. Roen is inapposite.

Rice v. Panchal, 875 F.Supp. 471 (N.D. Ill. 1994), also provides no support for Medica's position. The plaintiff in Rice sued his physician for malpractice and sued his ERISA health care plan under the state respondent superior doctrine. Rice held that while the plaintiff's malpractice claim against his physician was viable in state court, ERISA preempted his respondent superior claim against the ERISA plan.[1] The court then considered whether the plaintiff had stated a claim against the plan under ERISA based on the facts of his preempted state respondent superior claim. The court concluded that he had not because he did not expressly plead

[1] After the parties submitted the present matter, on appeal the Seventh Circuit held that the Rice plaintiff's respondeat superior claim did not fall within the complete preemption doctrine as it relates to federal jurisdiction, and remanded the case with instructions to the district court to dismiss the complaint for lack of jurisdiction. Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995).

a breach of fiduciary duty under ERISA and on the added ground that such claims did not implicate the plan's fiduciary duties. Unlike Rice, the Plaintiff here has alleged a claim of breach of a fiduciary duty under ERISA; she has not simply alleged Medica is liable for the malpractice of the treating physicians under a respondeat superior theory.

Likewise, Nealy v. U.S. Healthcare HMO, 844 F.Supp. 966 (S.D.N.Y. 1994), does not support Medica's argument. After rejecting as preempted by ERISA the plaintiff's state claims, the Nealy court refused to construe the plaintiff's state breach of fiduciary duty claim as an ERISA breach of fiduciary duty claim. The court held that the breach claim was preempted because the plaintiff sought extra-contractual damages not benefiting the plan itself. Id. at 974. As in Rice, the Nealy court dismissed the plaintiff's state claim against the plan and remanded the plaintiff's malpractice claim brought against the treating physician to state court. Again, unlike the Nealy plaintiff, Mrs. Shea seeks equitable relief here.

Finally, the Court does not find Altieri v. Cigna Dental Health, Inc., 753 F.Supp. 61 (D.Conn. 1990), supportive of Medica. As with the other cases cited by Medica, Altieri does not involve an alleged failure to disclose material facts affecting the interests of beneficiaries. At least facially, this case does, and therefore Altieri is irrelevant to Mrs. Shea's breach of a fiduciary duty claim. While Mrs. Shea's Amended Complaint retains at its heart a claim of negligence against Mr. Shea's treating physicians, the Court finds that her fiduciary duty claim against Medica is based on facts sufficiently separate as not to constitute a mere restatement of her state negligence claim.

Medica next argues that it had no duty to disclose the information Mrs. Shea alleges it was required to disclose. It asserts that 29 U.S.C. §§ 1021-31 provide the exclusive disclosure requirements under ERISA, and that these sections do not require ERISA plans to provide the information about

the financial relationship between the provider and the HMO that Mrs. Shea demands. As noted above, however, fiduciaries must communicate material facts affecting a beneficiary's interests. Anweiler, 3 F.3d at 991. The question then becomes, assuming the Eighth Circuit would follow this portion of Anweiler, was the alleged financial relationship between the plan and Mr. Shea's treating physicians the type of "material fact" the disclosure of which Anweiler demands?

The answer requires consideration of Anweiler and Rosen. In Rosen, the Third Circuit considered whether an insurance plan could deny the plaintiff benefits where it failed to notify him that his employer's contributions to the plan were in arrears and also failed to take action against the employer for continued refusal to contribute. The Rosen court reasoned from the principles of trust and held that the fiduciary insurance company breached its duty by neglecting to inform the plaintiff and other pensioners that their employer failed to make the contributions to the trust as required by the pension's language where that failure jeopardized their eligibility under the plan. Rosen, 637 F.2d at 599-600.

The Anweiler court considered whether the defendants breached a fiduciary duty by not informing the plan participant that a reimbursement agreement he signed was revocable. He had signed the reimbursement agreement at his employer's request, and the agreement designated the defendant insurance company as the beneficiary of his group life insurance policy for any overpayment owed at his death resulting from double benefits from social security. After his death, the defendant insurance company was paid the overpayment. The plan participant's widow would have been the beneficiary but for the reimbursement agreement. She sued in his behalf, alleging breach of fiduciary duty, because her husband had not been informed that he was not required to sign the agreement in order to receive his long-term benefits and that the agreement was revocable at will.

From the Third Circuit's holding in Rosen, the Seventh Circuit in Anweiler concluded that "[f]iduciaries must ... communicate facts affecting the interests of beneficiaries." Anweiler, 3 F.3d at 991. From this premise, Anweiler held that the defendants had a duty to give the plan participant full and complete material information concerning the reimbursement agreement at the time he was asked to sign it. Id. at 991-92. The court thus determined that the defendants breached their fiduciary duty under ERISA.

Despite the broad language of Anweiler, the Plaintiff here cites no authority, and the Court is aware of none, that suggests the "facts affecting the interests of beneficiaries" include the plan's payment procedures or policy where that policy might affect a physician's decision to provide care in a given way, or to refer a patient to a specialist. Taken to its logical conclusion, the Plaintiff's position would require ERISA health plans to disclose to each plan participant the details of each care-provider's payment process, including amounts paid to each physician for each service the physician provides, because every such detail might affect the physician's decision to provide care in one way or another, or whether to refer the patient. Anweiler does not support such a requirement. Indeed, the Plaintiff's position would permit dissatisfied plan participants to absorb a plan fiduciary into medical malpractice claims against negligent physicians based solely on any perceived disparity in the plan's payment procedure. This is not the type of misleading omission concerning participation in the plan that the Anweiler court considered. It is also not the type of information concerning one's jeopardized status with the plan the Rosen court addressed. Additionally, the information sought here is all too obvious. One might presume without the aid of ERISA-mandated disclosure that physicians receive less compensation when they no longer provide care to a patient after referral. This type of "financial disincentive" to referral

is not the type of "material fact" the disclosure of which Anweiler would require.

This holding precludes Mrs. Shea's ERISA claim against Medica, but leaves in tact her ability to pursue her malpractice claim based on the alleged negligence of Mr. Shea's physicians. Because of this finding, the Court need not address Medica's other bases in support of its motion, except to note that the Court considers the "Arbitrary and Capacious" claim of Count Five of the Amended Complaint, which is based on the same facts discussed here and which goes beyond this Court's Order granting leave to amend the Complaint, as subsumed by the Plaintiff's Breach of Fiduciary Duty Claim.

CONCLUSION

Mrs. Shea's claim against Medica should not fail for lack of standing because she brings the action as trustee for the heirs of Mr. Shea, and, as alleged, Mr. Shea would have remained a plan participant but for the defendants purported breach of fiduciary duty. Despite the opportunity to amend her Complaint, Mrs. Shea has failed to allege facts supporting her breach of fiduciary duty claim under ERISA against Medica; Medica had no duty to disclose details to plan participants of its policy and procedures regarding payment to treating physicians under the facts of this case. There remain no federal questions for this Court, and no party asserts this Court has jurisdiction otherwise. Therefore, Mrs. Shea's claims against the other defendants should remain unprejudiced by this decision and actionable in state court. See 28 U.S.C. §§ 1367 and 1447(c).

Accordingly, **IT IS HEREBY ORDERED** THAT:

1. Medica's Motion to Dismiss Plaintiff's Breach of Fiduciary Duty Claims against Medica (Clerk Doc. No. 57) is

GRANTED and the Plaintiff's claims against Medica are DISMISSED WITH PREJUDICE;

2. Because this Court now dismisses the only claim over which it has original jurisdiction, the Court declines to exercise its supplemental jurisdiction over the remaining state claims, and this case is therefore REMANDED to the state court from which it was removed, without costs;

3. The Clerk of Court shall MAIL A CERTIFIED COPY OF THIS ORDER to the Clerk of the Court of Hennepin County District Court, Minneapolis, Minnesota;

4. Medica's two appeals (Clerk Doc. Nos. 68 and 79) of Orders entered by Magistrate Judge Lebedoff are DENIED WITHOUT PREJUDICE AS MOOT.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: November 15, 1995.

/s/
Paul A. Magnuson
United States District Court Judge

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

Dianne L. Shea,
individually and as
trustee for the heirs
of Patrick Joseph Shea,

Civ. File No. 3-94-I 173

Plaintiff,

v.

ORDER

Sidney Esensten; Jeffrey A. Arenson;
Family Medical Clinics, a Minnesota non-profit
corporation; and Medica, a Minnesota non profit
corporation,

Defendants.

This matter is before the Court upon Defendant Medica's Motion to Dismiss pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. After full consideration of the submissions of the parties, and for the reasons stated following oral argument on this motion, the Court finds that the Plaintiff's claims against Medica are preempted under 29 U.S.C. § 1144(a), but that it is unclear from the facts now before the Court whether the Plaintiff could allege facts sufficient to support a Breach of a Fiduciary Duty claim under ERISA.

Accordingly, **IT IS HEREBY ORDERED** THAT:

Defendant Medica's Motion to Dismiss (Clerk Doc. No. 40) is GRANTED;

Plaintiff's State tort claims against Medica are DISMISSED WITH PREJUDICE; and

Plaintiff is given LEAVE UNTIL APRIL 28, 1995 TO AMEND her Complaint to include a Breach of a Fiduciary Duty Claim under ERISA.

Dated: April 22, 1995.

/s/
Paul A. Magnuson
United States District Court Judge

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

Dianne L. Shea,

Plaintiff,

Civ. No. 4-94-0610

v. MEMORANDUM OPINION AND ORDER

Sidney Esensten; Jeffrey A. Arenson; Family Medical Clinic, P.A., N/K/A Fairview Clinics; and Medica,

Defendants.

Plaintiff Dianne Shea moves to remand this action to state court under 28 U.S.C. § 1447. Following her husband's death on March 5, 1993, plaintiff filed this action in Hennepin County District Court on June 30, 1994. The complaint named as defendants Doctors Sidney Esensten and Jeffrey Arenson; the Family Medical Clinic, where the two doctors practiced; and Medica, the health maintenance organization which administered the deceased's health plan. The complaint did not name the deceased's employer, Seagate Technology, which paid at least two-thirds of the of the deceased's Medica premiums.

Plaintiff alleges that the defendant doctors caused her husband's death by failing to refer him to a cardiologist and that Medica's undisclosed payment policies provided the doctors a financial disincentive to make referrals. All counts in the complaint are based on state law. The counts against Medica are fraud, negligent misrepresentation, and tortious interference with the doctor-patient relationship and/or

contract. Medica removed the case to this court under 28 U.S.C. § 1441 on July 17, 1994.

Plaintiff moves to remand the case on the basis that this court lacks subject matter jurisdiction. Because the parties are not diverse, federal question jurisdiction is the only possible basis for jurisdiction. 28 U.S.C. § 1331. Under the well-pleaded complaint rule, a defendant may generally remove a case only if the plaintiff's complaint includes a claim arising under federal law. Gully v. First National Bank, 299 U.S. 109 (1936). Even if the plaintiff only makes state law claims, however, a case may be removed if those claims "relate to" an employee welfare benefit plan under 29 U.S.C. § 1144(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, et, seq.[1] Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64 (1987). Although the "related to" test is used to determine both removal jurisdiction and preemption, no issue of preemption is before the court at this time.

Plaintiff claims that her causes of action are not related to an ERISA plan. She argues first that Medica has not shown that the plan is governed by ERISA: "While, presumably, that test can be met in the case of the Seagate plan, it is the burden of the Defendants claiming federal jurisdiction to establish this." Plaintiff's Notice of Motion and Motion for Remand to State Court at 5. Based on the affidavit of Helen Zwak and the attached exhibits, however, Medica has demonstrated that it was administering an employee welfare benefit program for Seagate. Seagate was engaged in commerce. 29 U.S.C. §

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[1] Section 1144(a) of ERISA reads as follows:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and are not exempt under section 1003 (b) of this title.

29 U.S.C. 1144(a).

1003(a)(1). Further, the Medica plan provided ongoing medical benefits to employees, Seagate paid much of the cost, and none of the exceptions in 29 U.S.C. § 1003(b) apply. The plaintiff has not refuted any of Medica's proof regarding these facts. The plan Medica administered for Seagate is an ERISA employee benefit program.

Plaintiff next argues that the state law causes of action do not factually "relate to" an employee benefit plan under 29 U.S.C. § 1144(a). The Supreme Court has held that this section has an expansive sweep and that the relation between a state law and an employee benefit plan must be determined in a common sense fashion. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 44-47 (1987). "[A] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 111 S.Ct. 478, 483 (1990). Where the existence of a plan is a critical factor in establishing liability under a state law, the necessary connection exists. Id. As the following analysis of the state law claims shows, all of plaintiff's counts against Medica would require reference to the employee benefit plan and are therefore "related to" it.

In the fraud and negligent misrepresentation counts, plaintiff alleges that Medica failed to disclose details of how the preferred providers under the plan are compensated. Specifically, Medica allegedly withholds fifteen percent of its payments to participating clinics until an annual audit assesses each clinic's average cost per patient. According to the plaintiff, if the average cost is too high, clinics are penalized. Doctors therefore have an incentive to keep costs low. Plaintiff claims that this structure should have been revealed to the deceased to inform his decision regarding the refusal to refer him to a cardiologist.

Many cases have found that similar claims were "related to" an employee benefit plan under ERISA. See, e.g., Stock v. Share, 18 F.3d 1419, 1422 (8th Cir. 1994)

(misrepresentation and breach of contract claims); Hermann Hospital v. MEBA Medical and Ben. Plan, 845 F.2d 1286 (5th Cir. 1988) (fraud claim); Lea v. Republic Airlines, Inc., 903 F. 2d 624 (9th Cir. 1990) (same); Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272 (6th Cir. 1991) (negligent misrepresentation); Straub v. Western Union Tel. Co., 851 F.2d 1262 (10th Cir. 1988) (same).

The misrepresentations alleged in this case have a connection to the plan. If the deceased had not enrolled in the Medica plan, Medica would have had no duty whatsoever to the deceased, let alone the alleged duty to disclose to him its financial arrangements with its health care providers. If the misrepresentation counts were allowed to proceed, it could be necessary to determine the benefits to which the deceased was entitled under the plan, the benefits he might have been promised, and the benefits he actually received. Furthermore, the deceased consulted the defendant doctors because they were associated with the plan. Finally, if the state law causes of action were allowed to go forward and were successful, the disclosure requirements for plan administrators like Medica would be affected if they attempted to avoid similar liability under state law in the future. These causes of action could not be resolved without reference to the employee benefit plan under ERISA.

For similar reasons, plaintiff's state law claim for interference with the doctor-patient relationship and/or contract is related to the health plan. While the doctor-patient relationship generally is accorded a great deal of deference, the relationship in this case is a creature of the ERISA plan. Medica and its doctors enter into contracts to provide medical services to plan members. In fact, it would be impossible to administer a managed care plan without agreements between the plan and its participating doctors regarding procedures and payment. If the state law counts were allowed to proceed, reference to the plan would be necessary during litigation to determine the relationships among Medica, its providers, the

deceased, and the plan benefits. This is the basis of the plaintiff's interference claim so the count has the requisite connection to the plan to be "related to" it.

The leading case in the Eighth Circuit on tortious interference in this context, Kuhl v. Lincoln National Health Plan, 999 F.2d 298 (8th Cir. 1993), is helpful to consider. The Kuhl plaintiffs alleged that the health plan's delay in scheduling surgery caused the death of the insured. Id. at 300. The court held that their state law claim of tortious interference with the decedent's right to contract for medical care was preempted by ERISA. Id. at 302-03.[2] The principle appears applicable here also.

The conclusion that the plaintiff's counts against Medica are related to an ERISA plan is also supported by application of the six-factor test identified in Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital Inc., 947 F.2d 1341, 1344-51 (8th Cir. 1991). First, although the state law claims do not appear to "negate a plan provision," they could have an "impact on the plan's structure." Id. at 1345. If successful, the financial structure allegedly used by Medica to contain costs would be changed. Second and similarly, the state law claims could affect disclosure and referral arrangements

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[2] Other courts facing similar claims have reached the same conclusion. For example, in Rodriguez v. Pacificare of Texas, Inc., 980 F.2d 1014, 1016 (5th Cir. 1993), the plaintiff argued under state law that the defendant health maintenance organization's refusal to refer him to an orthopaedic specialist was a failure to "provide prompt and adequate medical coverage." The Fifth Circuit held that the plaintiff's state law claims were preempted by ERISA because "at bottom, [they] result from dissatisfaction over [the HMO's] handling of his medical claims." Id. at 1017. See also Tingey v. Pixley-Richards West, Inc., 953 F.2d 1124, 1131 (9th Cir. 1992) (finding interference with contract claim preempted because it "spring[s] from the handling and disposition of [plaintiff's] medical benefits insurance claim . . . ."); Maciosek v. Blue Cross & Blue Shield United of Wisconsin, 930 F.2d 536 (7th Cir. 1991) (tortious interference with doctor-patient relationship): Rollo v. Maxicare of Louisiana, Inc., 695 F.Supp. 245 (E.D.La. 1988) (same).

between the plan and its members, who are primary ERISA entities. The plaintiff's attempt to isolate the relationship between Medica and its providers does not change the fact that the three causes of action under consideration ultimately affect the benefits and information Medica must provide. As the Seventh Circuit has noted, "[A]rtful pleading of a claim nominally under state law cannot prevent removal." Anderson v. Humana, Inc., 24 F.3d 889, 891 (7th Cir. 1994).

Third, success under Minnesota common law would have an impact on plan administration. Arkansas Blue Cross, 947 F.2d at 1346-48. For example, Medica and other plans might have different disclosure requirements in Minnesota than in other states or might be required to use markedly different financial arrangements with their providers. Fourth, success on the state law claims could have a significant economic impact on the plan. If the tortious interference claim were allowed to go forward, for instance, Medica might be less able to contain costs. Fifth, preemption of the state law claims seems consistent with other ERISA provisions. For example, 29 U.S.C. § 1132(a) provides for civil enforcement of claims involving rights and benefits under a plan, and § 1132(c) provides a remedy if a plan administrator fails to meet the ERISA disclosure requirements. Given the considerations under the first five factors, it is unnecessary to consider the sixth--the traditional state power factor--because the Court of Appeals has found it useful only in "borderline" cases. Id. at 1350. The six-factor test confirms the conclusion that the three common law counts against Medica are "related to" the ERISA plan.

Even if the claims are related to the ERISA plan, however, plaintiff argues they should be preserved by the ERISA "savings clause," 29 U.S.C. § 1144(b)(2)(A), which states: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." The savings clause only applies to statutes which specifically

regulate the insurance industry. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 50 (1987); Baxter by and through Baxter v. Lynn, 886 F.2d 182, 185-86 (8th Cir. 1989). Plaintiff's claims are based, however, not on specific state statutes which regulate insurance, but on common law causes of action of general application.[3] Thus, the savings clause does not apply to the plaintiff's counts against Medica.

In summary, the plaintiff's three causes of action against defendant Medica are related to an employee benefit plan under ERISA. Further, the savings clause is not applicable to those common law counts. Therefore, there is federal question jurisdiction under 28 U.S.C. § 1331, and the case was properly removed.

ORDER

Accordingly, based upon the above, and all the files, records, and proceedings herein, IT IS HEREBY ORDERED that plaintiff's motion to remand to state court is denied.

Date: 10/12/94

/s/
Diana E. Murphy
Chief Judge

[3] In her Memorandum in Support of Motion for Remand to State Court ("Plaintiff's Memorandum"), the plaintiff argues for the first time that the common law causes of action were preserved under Minn. Stat. § 62D.12 Subd. 1. That statute does not appear to preserve common law causes of action; instead it merely references specific state statutes. The plaintiff has not pled any of the referenced statutes, and in fact argues that Medica "was subject to suit by insurance customers under the common law of the State." Plaintiff's Memorandum at 13. It is precisely those common law causes of action which are not aimed specifically at the insurance industry that are not preserved by the savings clause. The court therefore need not determine the relationship between the statutes referenced by § 62D.12 Subd. 1 and the savings clause.

§ 514. Effect on other laws

(a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(a)(b)(1994).

§ 3. Definitions

For purposes of this title:

(1) The terms **"employee welfare benefit plan"** and **"welfare plan"** mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,

(A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or

(B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002(1)(1994).

§ 300e. Requirements of health maintenance organizations

(c) Organizational requirements

Each health maintenance organization shall--

(1) (A) have--
(i) a fiscally sound operation, and
(ii) adequate provision against the risk of insolvency,

which is satisfactory to the Secretary, and (B) have administrative and managerial arrangements satisfactory to the Secretary;

(2) assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may (A) obtain insurance or make other arrangements for the cost of providing to any member basic health services the aggregate value of which exceeds $5,000 in any year, (B) obtain insurance or make other arrangements for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, (C) obtain insurance or make other arrangements for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year, and (D) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions;

42 U.S.C. § 300e(c)(2)(D) (1994).

Supreme Court, U.S.
FILED
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CLERK

No. 00-012

In the

Supreme Court of the United States

Sidney Esensten; Jeffrey A. Arenson; Family Medical Clinic, P.A., a Minnesota Non-Profit Corp.; Fairview, a Minnesota Non-Profit Corp.,

Petitioners,

v.

Dianne L. Shea,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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26 pp

QUESTION PRESENTED

DID THE EIGHTH CIRCUIT CONTRADICT THE DECISIONS OF THIS COURT IN FINDING THAT ERISA DOES NOT PREEMPT THE HIPPOCRATIC OATH?

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REASONS FOR DENYING THE WRIT

The District Court granted summary judgment preempting Mrs. Shea's State-law fraud and punitive damages claims against the Petitioner doctors. These claims were, in turn, premised on the professional obligations of doctors to disclose affirmatively a financial conflict of interest. Such obligations can be traced to ancient ethical canons and to development over the last generation of the doctrine of informed consent; doctors, in short, have fundamental duties of loyalty and disclosure that require them to advise their patients of a financial incentive against making a necessary specialist referral. In reversing this preemption ruling, the Eighth Circuit applied the precedents of this Court to reach the unsurprising conclusion that ERISA does not preempt the Hippocratic Oath. The duty of a treating physician to disclose a financial conflict remains an issue of State law and was never intended by Congress to be preempted by ERISA. The Court need not grant the writ to reaffirm the obvious.

The Petition solicits the interest of this Court (1) by positing issues not before it; (2) by misconstruing a rich body of recent decisions of this Court that have in fact considerably narrowed the scope of ERISA preemption; and (3) by misstating the facts of this case. In particular:

First, this Court has already declined to review the 1997 holding of the Eighth Circuit (*"Shea I"*) that ERISA preempts disclosure claims against ERISA plan administrators. The issues presented in *Shea I* cannot be resurrected now. Nor is there any reason to resurrect those issues given the consistency of both *Shea I* and the decision at bar (*"Shea II"*) with the Court's recent decision in *Pegram v. Herdrich*, 503 U.S. ___, No. 98-1949, slip op. (U.S. June 12, 2000)

Second, beginning with its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), and most recently in its June 2000 *Pegram* decision, this Court has applied a

pragmatic test to determine whether preemption is necessary to serve the purposes of ERISA. The connection with ERISA urged in support of preemption here is far too remote and peripheral to serve any bona fide ERISA purpose. It is clear that the Petitioner doctors themselves are not ERISA entities or fiduciaries and that the source of their duty to disclose has everything to do with traditional subjects of State law and nothing to do with ERISA.

By happenstance, the source of the conflict of interest was an HMO-Clinic contract that, in turn, governed medical care paid for by an ERISA plan set up by Mr. Shea's employer. Had the source of the conflict been the doctors' interest in an Indian gambling casino, no one would have been so bold as to claim preemption. In ERISA, as in other areas of law, rulings flow from logic or practical experience, not from happenstance. The Eighth Circuit has correctly applied the ERISA preemption decisions handed down by the Court since 1995. Its decision is too straight-forward, and the preemption law is too well-developed, to merit additional review by the Court.

Third, the Petitioners' statement of facts, the premise of which is that they rendered "perfect" medical care, cannot go unchallenged. *See* Sup. Ct. R.15.2. Apart from presenting the paradox that perfection kills, such a recitation ignores the procedural posture of the case. The preemption issue was presented via a summary judgment motion by the Petitioners; the facts must therefore be viewed in a light most favorable to Mrs. Shea.

I. THE COURT LACKS JURISDICTION TO DECIDE THE ISSUES PRESENTED IN *SHEA I*.

The present case has produced two Eighth Circuit decisions. The first decision held that ERISA ***did*** preempt a claim that the ERISA ***plan administrator*** (Medica) has a duty

to disclose physician incentive schemes that paid a bonus for denying specialist referrals and that exacted a penalty for granting such referrals. The Eighth Circuit further found that ERISA would allow a remedy for the wrong on a breach of fiduciary duty theory. Because Mrs. Shea preferred a State common law remedy, she contested the preemption ruling and petitioned this Court for certiorari. The Court denied the petition in October, 1997. *See Shea v. Esensten*, 107 F.3d 625 (8th Cir.), *cert. denied*, 522 U.S. 914 (1997) ("*Shea I*").

The second decision held that duty-to-disclose claims against non-plan fiduciary treating physicians are not preempted by ERISA. *Shea v. Esensten*, 208 F.3d 712 (8th Cir. 2000) (*Shea II*). This is the only decision that is before the Court. Much of the Petition is directed at the perceived inconsistency and inequity of preempting disclosure claims against plan administrators, on the one hand, and allowing a State tort remedy to stand against non-plan fiduciary doctors for failing to disclose, on the other. Such contentions are irrelevant given that this Court has already declined to review the former decision; they are better made to the Eighth Circuit in the form of a petition for rehearing, an option that Petitioners waived.

II. THE EIGHTH CIRCUIT'S DECISION FAITHFULLY APPLIES THIS COURT'S NARROW ERISA PREEMPTION TEST IN AN UNCONTROVERSIAL FASHION.

ERISA preempts State laws, including State tort suits, that "relate to" an ERISA plan. 29 U.S.C. § 1144(a); ERISA § 514. The scope of ERISA preemption is a pure issue of law reviewed de novo by an appellate court.

The Court has recently repudiated broad, literal constructions of the "related to" language of the preemption statute, given that, logically, relations stop nowhere. *Travelers*, 115 S. Ct. at 1677. "We simply must go beyond

the unhelpful text and frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.*

Because Congress intended to preserve the "historic police powers of the State includ[ing] the regulation of matters of health and safety", those seeking to preempt the State's exercise of such powers "bear[ ] the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.' *Travelers*, 514 U.S., at 654...." *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 117 S. Ct. 1747, 1751 (1997). Consequently, ERISA does ***not*** preempt a "'myriad of state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." *DeBuono*, 117 S. Ct. at 1752.

The Eighth Circuit previously found in this case that claims for fraudulent nondisclosure of financial incentives ***against the ERISA plan administrator*** are preempted by ERISA. *Shea I*, 107 F.3d 625. The Eighth Circuit further recognized that ERISA provides the sole remedy for a breach of this fiduciary duty. *Id.* This claim was resolved below, and Medica, the ERISA plan administrator, has been dismissed from the case.

By contrast, the preemption issue presented now is whether ERISA preempts claims of fraudulent nondisclosure of financial incentives against the non-plan fiduciary ***doctors*** themselves. Unlike Medica, the ***doctors'*** disclosure duties are not governed by ERISA; their duties are instead governed by ancient professional and ethical canons that predate ERISA by a millennium and that are the very stuff of traditional State law. Because there is absolutely no evidence of congressional intent in enacting ERISA to nationalize medicine and medical ethics – indeed, this was an option expressly rejected by Congress – ERISA preemption would serve no bona fide

ERISA purpose. Defendants cannot, therefore, overcome *DeBuono's* heavy presumption against preemption of the states' traditional police powers over matters of health and safety.

Whether ERISA preempts malpractice and fraud claims against a ***doctor*** (i.e., a non-plan fiduciary service provider to an ERISA plan) is neither governed by nor is it inconsistent with *Shea I.* Instead, the preemption rule in *Shea II* is a simple extension of the Court's holding in *California Division of Labor Standards v. Dillingham*, 117 S. Ct. 832 (1997). In *Shea II,* the Eighth Circuit applied the *Dillingham* rule via the two-pronged preemption test it had previously announced in *Wilson v. Zoellner*, 114 F.3d 713 (8th Cir. 1997). The first prong consists of determining whether the state law at issue made "reference" to ERISA plans. That is, did it act "immediately and exclusively upon ERISA plans"?; alternatively, was the "existence of ERISA plans ... essential to the law's operation"? *Wilson*, 114 F.3d at 716. If so, the state law was per se preempted.

A fraudulent misrepresentation claim against a doctor does not act exclusively upon ERISA plans nor is the existence of an ERISA plan essential to the tort. HMO incentives are not unique to ERISA plans and operate independently from ERISA plans. The doctors' duty to disclose such incentives is of general application and does not actually or implicitly refer to ERISA plans. Hence, the tort is not preempted under the first prong of the *Wilson-Dillingham* test.

The second prong of the test asks whether the state law to be preempted has an impermissible "connection" with an ERISA plan. *Wilson,* 114 F.3d at 717. This test is narrowly applied with an eye toward the underlying objectives of ERISA. *Id.; see also In re Home Health, Inc. v. The Prudential Insurance Co. of America*, 101 F.3d 600, 606 (8th Cir. 1996) ("The 'ultimate touchstone' in deciding whether ERISA preempts a state law is the Congressional purpose in

enacting ERISA"); Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35 (1996).

Using ERISA preemption to preserve the uniformity of the disclosure obligations of a plan administrator can be said to serve a bona fide ERISA purpose. In *Shea I*, the Eighth Circuit reasoned that forcing plan administrators to follow 50 different disclosure laws would contradict Congress' intent to ensure the "nationally uniform administration of employee benefit plans." *Id.*, 107 F.3d at 627.

This reasoning has no application when the party charged with a duty to disclose is not a plan administrator and when the duty to disclose is grounded in notions of informed consent and professional standards that pre-date ERISA and that have always been governed by State law. To be sure, this means that doctors in different States who contract with the same plan may have different disclosure obligations. But plan administrators already contract with doctors knowing that their licensure and professional obligations are governed by 50 different State systems. Even the Petitioner doctors concede that the interest in uniformity is not so compelling as to require the federal courts to nationalize the law of medical malpractice. The Doctors' disclosure obligations are simply one subset of State malpractice law; there is no reason to single out this subset for preemption.

In short, the Eighth Circuit decisions and *Shea I* and in *Shea II* comport with the pragmatic and functional preemption test announced by the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995). Preempting the disclosure duties of a plan administrator can be said to serve the ERISA purpose of making the disclosure duties of plan fiduciaries uniform; preempting the professional and ethical duties of doctors to disclose conflicts to their patients serves no such purpose.

None of this was changed by the Court's June 2000 *Pegram* decision. There the Court held that mixed treatment and eligibility decisions by HMO physicians are not fiduciary decisions under ERISA, and therefore do not state an ERISA claim. The case did ***not*** even present a preemption issue. Moreover, the Court based its ruling in part on its fear that recognizing such a broad ERISA claim would result in the very absurdity urged here by the Petitioner doctors: the misuse of ERISA to preempt claims against doctors.

> The mischief of Herdrich's position would, indeed, go further than mere replication of state malpractice actions with HMO defendants. For not only would an HMO be liable as a fiduciary in the first instance for its own breach of fiduciary duty committed through the acts of its physician employee, but the physician employee would also be subject to liability as a fiduciary on the same basic analysis that would charge the HMO.... Hence, the physician, too, would be subject to suit in federal court applying an ERISA standard of reasonable medical skill. This result, in turn, would raise a puzzling issue of preemption. On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim.... We could struggle with this problem, but first it is well to ask, again, what would be gained by opening the federal courthouse doors for a fiduciary malpractice claim, save for possibly random fortuities such as more favorable scheduling, or the ancillary opportunity to seek attorney's fees. And again, we know that Congress had no such haphazard boons in prospect when it defined the ERISA fiduciary, nor such a risk to efficiency of

federal courts as a new fiduciary-malpractice jurisdiction would pose in welcoming such unheard-of fiduciary litigation.

The Petitioner Doctors protest that *Shea I*'s recognition of an ERISA claim against an HMO/plan administrator for breach of the fiduciary duty to disclose somehow runs afoul of *Pegram*. However, the Court has already reviewed and declined a petition for certiorari filed from that decision. Moreover, the Court in *Pegram* was careful to note that *Pegram* was not a duty-to-disclose case. *See, Pegram*, slip op. at footnote 8. Accordingly, neither *Shea I* nor *Shea* II contradicts the analysis of *Pegram*.

III. PETITIONERS HAVE MISSTATED THE FACTS.

The Petitioner Doctors have provided the Court with a one-sided, argumentative statement of facts, the thesis of which is that they rendered "perfect" care to the deceased Patrick Shea. Petition for Writ of Certiorari at p. 10.

The Petitioner Doctors, Defendants below, presented the ERISA preemption issue on a motion for partial summary judgment. Given this procedural posture, the facts must be viewed in a light most favorable to Mrs. Shea. *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574(1986). The test is whether "the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no genuine issue for trial." *Id.* at 586-87.

Mrs. Shea's failure to prevail at a later state court trial of a different medical malpractice theory – involving the duty to refer as opposed to the duty to disclose – is irrelevant for three reasons. First, the theories are different. Second, the state court decision is currently on appeal to the Minnesota Court of Appeals given that, *inter alia*, the trial court refused

to allow Mrs. Shea to impeach the doctors with evidence of HMO incentives against referral. And third, this state court trial occurred after the federal district court granted partial summary judgment slicing up Mrs. Shea's case.

Mrs. Shea relies on the exhaustive statement of facts in her briefs filed with the Eighth Circuit as the proper basis for reviewing the legal issues presented here. The following facts bear repeating.

A. MEDICAL HISTORY.

Plaintiff-Respondent Dianne L. Shea ("Mrs. Shea") is the widow of Patrick Joseph Shea("Mr. Shea"), who died of heart failure at the age of 40 on March 5, 1993. Mrs. Shea is the mother of two children, who were age 14 and 12 at the time of their father's death. Appellant Shea's Eighth Circuit Appendix ("App.") 440-42.

With the exception of diabetes, Mr. Shea suffered from every known risk factor for heart disease. He was a white male smoker, age 40, with high cholesterol and a strong family history of early death from heart disease. He also suffered from chest pain that on one occasion eight months before his death was severe enough to hospitalize him while on business in Thailand. U.S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. J at p. 34 (Dr. Davis deposition), Ex. C (Thai medical records), Ex. D (admission to same).

After he was discharged from the Thai hospital, Mr. Shea immediately returned to Minnesota and made an appointment to see Defendant Dr. Sidney Esensten ("Dr. Esensten") on July 6, 1992. Dr. Esensten had served as Mr. Shea's family doctor for several years. He practiced at the Defendant Family Medical Clinic in Minneapolis, Minnesota (the "Clinic"). App. 429-35.

Mr. Shea had previously consulted with Dr. Esensten on several occasions regarding his family history and cholesterol level sufficiently elevated to manifest itself in cholesterol

plaques that were removed from his eyelids in 1989. At Mr. Shea's insistence, Dr. Esensten's colleague, Defendant internist Dr. Jeffrey Arenson ("Dr. Arenson"), administered a electrocardiograph exercise stress test in February 1992. The test was negative. Dr. Esensten consistently assured Mr. Shea that he was too young and did not have enough cardiac symptoms. App. 40-46, 382-91.

Mrs. Shea was present at the July 6, 1992 appointment. Dr. Esensten was aware that both of Mr. Shea's parents had died of heart disease in their fifties and that Mr. Shea suffered from high cholesterol that had not been resolved by prescription of diet and medication. Despite this, despite all of Mr. Shea's risk factors, despite Mr. Shea's hospitalization in Thailand the previous week for chest pain which the Thai doctor described to Dr. Esensten over the telephone as being angina pectoris, despite his failure to obtain and review the Thai medical records, and despite lacking any expertise in the area of cardiology, Dr. Esensten unequivocally ruled out heart disease. Once again Dr. Esensten advised that Mr. Shea was too young and did not have enough symptoms. He then successfully dissuaded the Sheas from seeking out a second opinion from an expert cardiologist, which they would have done at their own cost. App. 40-46, 433.

The sole basis for Dr. Esensten's diagnosis was that Mr. Shea said he had produced a normal EKG and a normal treadmill test. Dr. Esensten never reviewed the test data from Thailand, though he was aware that Mr. Shea had produced a normal EKG and treadmill test during an examination by Dr. Arenson back in February of 1992. App. 429-35.

In the three months following this fateful July 6, 1992 appointment, Mr. Shea consulted with Dr. Esensten or Dr. Arenson a total of 11 times – on July 6, July 8, July 11, July 22, August 10, August 14, August 18, August 19, August 24, September 10, September 17, and October 6. The medical records characterize Mr. Shea's complaints on these dates as including his hospitalization in Thailand for "SOB [shortness

of breath], dizziness, tightness in his chest"; "belching"; "slight soreness in the left upper quadrant"; "backache"; "distress"; "irritable stomach"; "abdominal pain type symptoms"; "generalized malaise"; "occasional fever"; "occ. dizziness"; "pain in the left side of his adb. after working in his yard; "left upper quadrant pain"; "dizziness, light headedness, sore throat, some rining [sic;] in his ears"; "pain in the left lower quadrant" that is "constant", "dull", and "always there"; "another episode of the light headed, dizzy feeling"; "lower left quadrant abd. pain"; "symptoms in his chest and hands"; "high cholesterol"; "sinus headaches"; a right ear that "buzzes"; "gas and distress on the left side of abdoman [sic]"; and "twitches in the side". U. S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. A (Clinic medical records).

Any abdominal or gastroenterological problem was ruled out by a colonoscopy performed on September 3, 1992. The treating specialist, Dr. Tanghe, characterized the Thai work up and observation as "apparently not conclusive." "At this point, the patient has minimal symptoms, referring to the digestive tract itself," Dr. Tanghe wrote. Dr. Tanghe found no diverticulitis and a "[b]asically normal bowel with no pathology seen to explain patient's symptoms." U. S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. A at pp. 300114-16.

All of which left "hyperventilation" as Dr. Esensten's and Dr. Arenson's diagnosis of Mr. Shea. And the root cause of the hyperventilation was ascribed to "anxiety." However, Mr. Shea denied being anxious and he was never referred for psychological treatment of his "anxiety." App. 381-99, 429-35.

Dr. Arenson claimed he was referred Mr. Shea for a second opinion regarding constant pain in the lower left quadrant of the abdomen. Dr. Arenson claimed he never spoke with Dr. Esensten about the referral. Nor did he undertake a thorough review of Mr. Shea's chart or Mr.

Shea's Thai records. Dr. Arenson's notes did acknowledge a positive family history for coronary disease, and he conceded that Mr. Shea complained of chest tightness. Dr. Arenson believed that all of Mr. Shea's symptoms, including chest tightness, were caused by hyperventilation brought on by anxiety. Although the symptoms were serious enough to cause two hospitalizations and a dozen visits to his doctor in the summer of 1992, Dr. Arenson did not think the anxiety was serious enough to be treated by or to merit a referral to a psychologist. He prescribed a mild tranquilizer, which Mr. Shea did not take. Dr. Arenson denied knowing that Mr. Shea had requested a referral to a cardiologist. App. 381-99.

Mr. Shea stayed away from the Clinic until February 1, 1993, when he complained of "heartburn." Dr. Arenson noted Mr. Shea's elevated cholesterol and family history of heart disease. Dr. Arenson stated that he had no reason to be concerned about heart disease on the part of Mr. Shea in February 1993. Like Dr. Esensten, he had ruled out heart disease. App. 392-99.

Mr. Shea died the next month, after experiencing chest pain in his office in Bloomington, Minnesota on March 5, 1993. In reliance on his doctors' advice, he did not seek out emergency care. Instead, he got in his car an drove across town to the Clinic, passing at least two hospital emergency rooms on the way. He stopped several blocks from the Clinic, executed a parallel park, and then died in his car. App. 46-47; U.S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. A at pp. 300008-15 (autopsy records).

The autopsy revealed 80-85% blockage in the left anterior descending coronary artery and 50-60% blockage in the right coronary artery. The final diagnosis was that Mr. Shea had suffered from arteriosclerotic heart disease sufficiently long-standing to have become partially calcified and had experienced sudden cardiac death. Case No. 96-CV-406, Docket No. 158, Ex. A at pp 300008-15.

B. UNDISCLOSED MANAGED CARE INCENTIVES.

Mr. Shea participated in his employer's group health plan (the "Plan"), which, in turn, offered coverage under the "Share" HMO "plan." Share later became known as "Medica Primary." Mr. Shea accepted this coverage for himself and his family from 1989 through the date of his death on March 5, 1993. Mrs. Shea continued coverage for a brief time thereafter. App. 50-51.

The Share/Medica Primary coverage required Mr. Shea to select a "primary care office" from a list that included the Defendant Clinic. Mr. Shea selected the Clinic, which thereby assumed responsibility for coordinating all covered health services. Specialist care required a written referral authorization from the Clinic. Apart from the premiums paid in advance for this coverage, and the $10 to $15 co-payments made by the patient, there was no additional patient charge for visits to the Clinic or to referred specialists. Similarly, drug prescriptions were covered unless otherwise specifically excluded, subject to a $ 9.00 per prescription unit co-pay. Hospital services were also broadly covered, if "ordered, provided or arranged under the direction of your primary care office." The charges to the patient were limited to a $40 per visit co-pay for hospital emergency room services. Case No. 94-CV-1173, Docket No. 10 (Zwak Affidavit, which, in turn, attaches Medica Primary Certificate of Coverage).

The relationship between Medica and the doctors who would provide care to Plan participant was tersely described in booklets distributed by Medica on behalf of the Plan as the subject of a "contract", whose terms are not disclosed. *Id.*, Medica Primary Certificate at p. 49. Medica disclosed nothing about the underlying contracts it negotiated with the providers. So far as the patients knew, their family doctors were paid for services rendered, had no financial interest which conflicted with their "sole responsibility" for providing

health care to the patients, and had no responsibility for paying for their needed specialist care, expensive drug care, or hospital charges. *Id.*

Unbeknownst to Mr. Shea, the Clinic had executed a contract with Medica that created a series of financial incentives and disincentives that potentially conflicted with the Clinic's duty to refer the patient for needed specialist care, drug therapy, and hospital care. App. 50-53.

The Clinic executed its first contract with Share in November of 1988. That contract was entitled "Two Pool Primary Care Provider Participation Agreement" (hereafter, the "Pool Agreement"). App. 400-28. A similar agreement was executed in 1991, and was assigned to Medica when that entity was created by the merger between Share and Physicians Health Plan on or about the period 1991-92. Case No. 96-CV-406, Docket No. 108 (Third Amended Complaint ¶ 65); Docket No. 116 (Medica Answer ¶ 65). Pursuant to the Pool Agreement, and the master contract signed between Share and the Plan, Seagate forwarded premium payments to Share (later, Medica) for each plan participant who elected to enroll in the Share HMO, later known as the Medica Primary HMO. U.S. District Court, D. Minn., Case No. 94-CV-1173, Docket No. 10 (Zwak Affidavit, attaching master contract between the Plan and Medica); App. 400-28; U.S. District Court, D. Minn., Case No. 96-CV-406, Docket No. 158, Ex. I (1991 Pool Agreement).

Share (later Medica) allocated to administrative costs 15% of the premium payments forwarded by the Plan for each enrolled participant. Then it deposited into a "PCPCF" fund 49% of the premium dollars of each Plan participant who selected the Clinic as his or her primary care office. This "PCPCF" fund was used to pay the Clinic for the primary care provided to those Plan participants and beneficiaries. Regardless of whether any Plan members were seen at the Clinic in any given month, the amount of premium in the PCPCF fund, less deductions to be described below, was paid

to the Clinic at the end of the month. Similarly, if Plan members visited the Clinic each day of the month, the same amount of premium in the PCPCF fund, less deductions to be described below, was paid to the Clinic at the end of the month. App. 400-27 (1988 Pool Agreement); App. 201-39 (explanation of pool agreement at Cooney deposition). This is known in the industry as "capitation", which has been defined as follows:

> **Capitation** A monthly fixed payment to your health care provider regardless of how much care is provided. This payment is usually set as a per member per month (PMPM) dollar amount. Capitation payments for different medical and surgical specialties vary widely.

Michael E. Cafferky, MANAGED CARE & YOU 182 (1995).

Thus, the Clinic would generally be paid a fixed amount per member per month regardless of how many times the member was seen at the Clinic. The reason the amount actually paid per month would vary was that money would be deducted from the PCPCF fund each month and be used to pay two very important items. ***First***, the fees of specialists to whom the Clinic referred Plan members were paid out of the PCPCF fund. ***Second***, the cost of drugs (less co-pay) prescribed by the Clinic was paid out of the PCPCF fund. Therefore, the more referrals, the more the monthly deduction from the PCPCF fund, the less there is left over for the Clinic at the end of the month. Similarly, the more drugs prescribed for Plan members, the less the money left over for the Clinic at month end.

The 36 cents of each premium dollar that remained after 15 cents was paid to Medica and after 49 cents was paid into the PCPCF fund was deposited into the ICF fund. This fund

was used to pay hospital charges. This would include the hospital room charges, surgical costs, and costs of certain outpatient procedures performed at hospitals and specialized clinics that were defined to be inpatient costs for the purposes of the ICF fund (e.g., blood products, psychiatry, dental, chemical dependency, dialysis, same day surgery). App. 419; App. 218-27 (explaining Two Pool Agreement).

The ICF fund entailed a higher level of upside and downside risk than did the PCPCF fund. Unlike the PCPCF fund, the Clinic did have to cover a portion – 50% – of any year-end deficit in the ICF fund. If too many Medica/Share patients were hospitalized, then the Clinic could be put in the position of paying for tens of thousands of dollars or even hundreds of thousands of dollars for its one-half portion of the resulting deficit. On the bright side, the Clinic would receive 65% of any surplus left over in the ICF fund. Medica would receive the remaining 35%. App. 218-27.

C. THE MATERIALITY OF DISCLOSURE.

Unfortunately, neither Dr. Esensten, Dr. Arenson, nor the Clinic ever disclosed to Mr. Shea, at any level of specificity or generality, this governing web of managed care incentives against specialist care. Mrs. Shea offered to prove that had her husband known of the conflict, he would not have so uncritically relied on his doctors' advice against seeking a specialist, and he would have sought out on his own the cardiology consult that would have saved his life. App. 52 (¶ 82 of verified complaint). In short, the nondisclosure was highly material. Materiality in this sense is in the eyes of the patient. Mrs. Shea's expert, Dr. Siegler, opined that the conflict of interests was material from the ***patient's*** perspective. Regardless of whether the incentives can be shown to have actually affected medical judgment, their disclosure was necessary for Mr. Shea to make his own judgment as to his own comfort level with continuing to treat

with the doctor or to rely on his advice. The disclosure was a necessary part of informed consent. App. 60-67.

For the purposes of establishing the grossness of the violation, measuring the amount of damages, and putting the disclosure obligation into its proper context, it is further relevant to consider the ***doctors'*** perspective as well. Mrs. Shea offered to prove that the incentives were a matter of material, grave, and continuing concern to the doctors and their Clinic and affected their medical judgment. In particular: (1) the incentives had a direct and significant effect of the bottom line of the Clinic and doctors; (2) the doctors were therefore informed as to whether a patient in question was a Medica patient; and (3) the incentives changed the way the doctors treated those patients.

It should be noted in this respect that the Petitioner Doctors themselves questioned the negative effect as well as the ethics of the Share/Medica incentives. At an August 10, 1988 Clinic meeting, Petitioner Dr. Arenson himself made it very clear that managed care incentives would have an unconscionable effect on the doctors' ability to prescribe necessary care. The minutes of that meeting include the following memorialization:

> SHARE: Dr Arenson was present at the meeting to voice his opinion and philosophy relative to capitated health plans and Share in particular. He stated that it was not possible, in his opinion, to give patients the appropriate level of care that they needed in many cases. He also stated that the severe financial risk is more than he is willing to accept as a physician.

App. 482.[1]

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[1] The Eighth Circuit declined to consider this proffer of evidence because the facts came to light after the District Court had granted the partial summary judgment at issue. This Court may elect to consider such

D. THE ETHICAL AND PROFESSIONAL MANDATE TO DISCLOSE.

Dr. Mark Siegler, the director of the Center for Clinical Medical Ethics at the University of Chicago and a practicing clinician, submitted an affidavit finding that the standard of professional care required doctors who entered into this kind of managed care contract to disclose the incentives against referrals created by that contract. App. 60-67. That disclosure would include:

> [A] disclaimer that under the HMO contract, the clinic's bonus would be increased by not referring patients to specialists and that if too many patients were referred to specialists by the clinic, the clinic may be forced to pay a penalty to the HMO or capitated plan. Absent such disclosures, the reasonable patient is not in a position to make an informed and prudent choice about his health care.

App. 65. Dr. Siegler further opined that the clinician had an ***ethical*** duty in such circumstances "to disclose to the patient the clinician's financial stake in the referral decision." App. 66.

The only other medical ethicist retained in this matter, Dr. Allen, Fairview's expert, ***agreed*** with the general principal that in some circumstances, a doctor must disclose a financial incentive that may affect medical judgment. To be sure, Dr. Allen would find disclosure appropriate only in an "extreme"

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evidence, as well as the other evidence stricken by the Eighth Circuit, pursuant to its prerogative to scour the record to find alternative bases on which to affirm the result below.

case of "undue influence" -- and he did not view the present case as "extreme."

Q. Dr. Allen, would you agree that if a financial incentive could affect the judgment of a physician, that that financial incentive must be disclosed to the patient?

****

A. I disagree.

Q. And why do you disagree, Dr. Allen, with that statement?

A. I think that -- I can conceive -- I can certainly conceive of an extreme instance where a physician may have a direct -- a very direct incentive to refer a patient to a specific pharmaceutical company or for a specific product or whatever where he's incented to and will benefit from that referral, however, as a general rule, I don't believe that physicians have an obligation to disclose any of the contractual relationships with which they have with vendors or with payers. And specifically related to this case, I do not see that there is any significant amount of undue influence on the physicians practicing in this clinic such that they should have felt an obligation to disclose the nature of their relationship with the health plan to the patients at any time.

App. 309.

Whether the present circumstances required disclosure, as opined by Dr. Siegler, or whether they were insufficiently compelling to require disclosure, as opined by Dr. Allen, presented an issue of fact for trial. Both experts agree that there are certain professional and ethical duties requiring affirmative disclosure of financial incentives.

The Second Amended Complaint included the nondisclosure theory at Count Three, entitled "Fraud and Negligent Misrepresentation as against Defendants Esensten, Arenson, and the Clinic." App. 124-26. The count alleged that the governing standard of professional care required the disclosure; that had the disclosure been made, Mr. Shea would have sought out on his own the cardiology consult that would have saved his life; and that the doctors and Clinic were therefore liable for compensatory damages. Count Five alleged the right to punitive damages by reason of "deliberate disregard for the rights and safety of Pat Shea" in not making the required disclosures. App. 128-29.

CONCLUSION

For the foregoing reasons, Respondent Mrs. Shea respectfully requests that this Honorable Court deny the petition.

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Respectfully Submitted,

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